

**CHARLES F. MOONEY, M.D. P.A.
PATIENT INFORMATION SHEET**

Patient Last Name:	Home Phone: ()
First Name: M.I.	Work Phone: () Extension
Mailing Address:	Cell Phone: ()
City: ST: Zip:	Date of Birth: Age:
Physical Address if different from above:	Social Security #:
Employer: Occupation:	Sex: M F Marital Status: S M D W Separated
Employer Address:	In case of emergency Contact:
City: ST: Zip:	Emergency Contact Phone: ()
Referred by:	Primary physician:

PRIMARY INSURED INFORMATION

Insured Last Name:	Insured Employer:
Insured First Name: M.I.	Insured Employer Address:
Insured Date of Birth:	City: ST: Zip:
Insured Social Security #:	Name of Ins. Co.:
Insured Home Phone#:	Insurance ID#:
Insured Work Phone#:	Insurance Group #:

SECONDARY INSURED INFORMATION

Insured Last Name:	Insured Employer:
Insured First Name: M.I.	Insured Employer Address:
Insured Date of Birth:	City: ST: Zip:
Insured Social Security #:	Name of Ins. Co.:
Insured Home Phone#:	Insurance ID#:
Insured Work Phone#:	Insurance Group #:

All co-payments, co-insurance, and deductibles must be paid at the time of service. In case of surgery, prepayment of your co-insurance must be paid before surgery is scheduled. I understand that I am responsible for any fees associated with the collection of my account balance.

I AUTHORIZE Charles F. Mooney M.D., P.A. TO RELEASE ANY MEDICAL OR OTHER INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADM. & HEALTH CARE FINANCING ADM. OR ITS INTERMEDIARIES OF CARRIER, COMMERCIAL INSURANCE COMPANIES, INSURANCE COMPANIES, INSURANCE ADJUSTORS, ATTORNEYS, MY REFERRING PHYSICIAN OR CONSULTANTS WHICH MAY BE NECESSARY TO PROCESS CLAIMS ON MY BEHALF.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS BE MADE TO Charles F. Mooney M.D., P.A. I authorize Charles F. Mooney, M.D. P.A. to obtain my medication history electronically.

SIGNATURE: _____ DATE: _____

Email address: _____ @ _____ NAME OF PHARMACY & TOWN _____

Comprehensive History & Physical

Patient Name: _____ DOB: _____ Age: _____ Sex: _____

Primary Doctor: _____ Other Doctors: _____

Reason for today's visit: _____ Date first noticed: ____/____/____

Are you disabled? Yes No Reason: _____

Is it due to a work related injury? Yes No If yes, please specify date of injury: ____/____/____

Recent diagnostic tests: Record Type _____ If yes, please indicate date and where tests were done.
X-ray/Ultrasound/CT: Yes No _____
Labs: Yes No _____

Date of last mammogram: ____/____/____ Date of last pap: ____/____/____

Date of last menstrual cycle (if applicable): ____/____/____ Number of Pregnancies: ____ Live births: ____

Do you do regular breast self-exams? Yes No Have you ever noticed a breast lump or discharge? Yes No

Personal Medical Symptoms/History (Date diagnosed or symptoms started)

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdominal Pain _____ | <input type="checkbox"/> Cirrhosis _____ | <input type="checkbox"/> Thyroid Disorder _____ |
| <input type="checkbox"/> Anal Fissure _____ | <input type="checkbox"/> Colon polyps _____ | <input type="checkbox"/> IBS _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Liver Disease _____ |
| <input type="checkbox"/> Anesthesia _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Melanoma _____ |
| Complications _____ | <input type="checkbox"/> Diverticulitis _____ | <input type="checkbox"/> Pilonidal Cyst _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Diverticulosis _____ | <input type="checkbox"/> Rectal Bleeding _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> DVT _____ | <input type="checkbox"/> Rectal Pain _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> GERD _____ | <input type="checkbox"/> Sleep Apnea/Snoring _____ |
| <input type="checkbox"/> Cancer (any) _____ | <input type="checkbox"/> GI Bleeding _____ | Use CPAP <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Change in bowel _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> TB _____ |
| habits _____ | <input type="checkbox"/> Hemorrhoids _____ | <input type="checkbox"/> Weight _____ |
| Diarrhea/Constipation _____ | <input type="checkbox"/> Hernia _____ | Loss/Gain _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Hyperlipidemia _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Crohn's Disease _____ | <input type="checkbox"/> Hypertension _____ | |

Personal Past Surgeries (Please indicate date)

- | | | |
|---|---|--|
| <input type="checkbox"/> Abdominal _____ | <input type="checkbox"/> Eye _____ | <input type="checkbox"/> Orthopedic _____ |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Rectal _____ |
| <input type="checkbox"/> Breast _____ | <input type="checkbox"/> Hernia Repair _____ | <input type="checkbox"/> Thyroid/Parathyroid _____ |
| <input type="checkbox"/> Cardiovascular _____ | With/Without Mesh | |
| <input type="checkbox"/> Colonoscopy _____ | <input type="checkbox"/> Hysterectomy/Vasectomy _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> C-Section _____ | | <input type="checkbox"/> Other _____ |

Personal Life Style Review

- | | |
|---|--|
| <input type="checkbox"/> Alcohol Use _____ | <input type="checkbox"/> STD _____ |
| <input type="checkbox"/> Drug Use _____ | <input type="checkbox"/> Tobacco Use _____ |
| <input type="checkbox"/> Mental Health Problems _____ | |

ALLERGIES: _____

Family History (Please indicate relationship)

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Heart Disease _____ | |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Liver Disease _____ | |

Vitals

Temp: _____ BP: _____ Pulse: _____ Wt: _____ Ht: _____ BMI: _____ Resp: _____

Diagnosis: _____

Physician Signature: _____ Date: _____

