

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

Patient Last Name:	Emergency contact other than parent:
First Name: M.I.	Emergency Contact Phone: ()
Mailing Address:	Patient Date of Birth: Age:
City: ST: Zip:	Patient Social Security #:
Home Phone: ()	Sex: M F
Physical Address if different from above:	Primary physician:
Name of School and school status (part/full time)	Referring Physician:

PARENT OR GUARDIAN

Last Name:	Home phone#: ()
First Name: M.I.	Cell phone#: ()
Date of Birth:	Employer: Occupation:
Social Security #:	Employer Address:
Home Address:	City: ST: Zip:
Email Address:	Employer Phone #:

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.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

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: _____

Charles F. Mooney, M.D., P.A.

PF-2000 Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Charles F. Mooney, M.D., P.A.** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Charles F. Mooney, M.D., P.A. may or may not agree to restrict the use or disclosure of your protected health information.

If **Charles F. Mooney, M.D., P.A.** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Charles F. Mooney, M.D., P.A. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to **Charles F. Mooney, M.D., P.A.** to use and disclosure my health information in accordance with it.

Name of Patient (Print or Type)

Authorizing Signature **Date**

If indicated, print name of personal representative:

List anyone we are authorized to discuss your protected health information with and *give their relationship to you* (family members, friends, caretakers):

