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: _____/_____/_____

Record Type If yes, please indicate date and where tests were done.
Recent diagnostic tests: 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)

- ☐ Abdominal Pain_____
- ☐ Anal Fissure_____
- ☐ Anemia_____
- ☐ Anesthesia Complications_____
- ☐ Anxiety_____
- ☐ Arthritis_____
- ☐ Asthma_____
- ☐ Cancer (any) _____
- ☐ Change in bowel habits_____ Diarrhea/Constipation
- ☐ Chest pain_____
- ☐ Crohn's Disease _____
- ☐ Cirrhosis_____
- ☐ Colon polyps _____
- ☐ COPD_____
- ☐ Diabetes_____
- ☐ Diverticulitis_____
- ☐ Diverticulosis_____
- ☐ DVT_____
- ☐ GERD_____
- ☐ GI Bleeding_____
- ☐ Heart Disease_____
- ☐ Hemorrhoids_____
- ☐ Hernia_____
- ☐ Hyperlipidemia_____
- ☐ Hypertension_____
- ☐ Thyroid Disorder_____
- ☐ IBS_____
- ☐ Liver Disease_____
- ☐ Melanoma_____
- ☐ Pilonidal Cyst_____
- ☐ Rectal Bleeding_____
- ☐ Rectal Pain_____
- ☐ Sleep Apnea/Snoring _____ Use CPAP ☐ Yes ☐ No
- ☐ TB_____
- ☐ Weight Loss/Gain_____
- ☐ Other_____

Personal Past Surgeries (Please indicate date)

- ☐ Abdominal _____
- ☐ Appendectomy_____
- ☐ Breast_____
- ☐ Cardiovascular_____
- ☐ Colonoscopy_____
- ☐ C-Section_____
- ☐ Eye_____
- ☐ Gallbladder_____
- ☐ Hernia Repair_____ With/Without Mesh
- ☐ Hysterectomy/Vasectomy _____
- ☐ Orthopedic_____
- ☐ Rectal_____
- ☐ Thyroid/Parathyroid _____
- ☐ Tonsillectomy_____
- ☐ Other_____

Personal Life Style Review

- ☐ Alcohol Use _____
- ☐ Drug Use_____
- ☐ Mental Health Problems_____
- ☐ STD_____
- ☐ Tobacco Use_____

ALLERGIES:_____

Family History (Please indicate relationship)

- ☐ Cancer_____
- ☐ Breast Cancer_____
- ☐ Colon Cancer_____
- ☐ Diabetes_____
- ☐ High Cholesterol_____
- ☐ High Blood Pressure_____
- ☐ Heart Disease_____
- ☐ Liver Disease_____
- ☐ Epilepsy_____
- ☐ Other_____

Vitals

Temp:_____BP:_____Pulse:_____Wt:_____Ht:_____BMI:_____Resp:_____

Diagnosis:_____

Physician Signature:_____ Date:_____

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

Phone: (903) 957-6000
Fax: (903)957-6003
600 East Taylor Ste 308
Sherman, TX 75090

Chart Medication Record

NOTE TO PATIENT:
Please fill in the section below with your name, etc. and use the section below that to list any medications you are taking.

Patient Name: _____Date of Birth:_____

Allergies: _____

Pharmacy of Choice:_____Pharmacy Phone Number:_____

TODAY'S DATE	PRESCRIPTION AND DIRECTIONS

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):

_____

_____