Hamid Moayad, D.O., P.A. Neurology
Patient Registration Form, Please Print

Date: _____ Drivers License # _____
Name: _____ Date of Birth_____ Age ____ Sex _____
Home Addres: _____ Phone Number _____
City: _____ State: _____ Zip _____

Spouse or Parent Name: _____ Marital Status _____
Name and Address of Employer _____
Name and Address of Spouse Employer _____
Social Security: _____ Spouse SS# _____
Type of Ins: ___ Group ____ HMO ___ PPO __ Champus ____ Medicare/Medicaid ____ W/C _____

Primary Insurance Company Name: _____
Insurance Company Address: _____
Insured Name: _____
Insured Employer: _____
Policy # _____

Secondary Insurance Company Name: _____
Insurance Company Address: _____
Insured Name: _____
Insured Employer: _____
Policy # _____

Workers Comp _____
Date of Accident _____ Employer: _____
Employer Address: _____
How Injury Occurred: _____
Medicare # _____ Part A _____ Part B _____
Referred by DR: _____

Health History:		***Medical Allergies***	***Medications Taking Now***
High Blood Pressure	Yes ____ No ____	_____	_____
Diabetes	Yes ____ No ____	_____	_____
Prolonged Bleeding	Yes ____ No ____	_____	_____
Easy Bruising	Yes ____ No ____	_____	_____
Pregnant Now	Yes ____ No ____	_____	_____

Significant Medical/Surgery History:

_____
_____
_____
_____
_____

Reasons for Seeking Medical Attention:

_____
_____
_____
_____
_____

I hereby assign all my medical benefits, including Major Medical, PIP, Medicare, Private Insurance and any other health plans to Hamid Moayad, D.O. , P.A. I hereby authorize said assignee to release all information necessary to secure payment. I understand that I am financially responsible for all charges. All payments to be made to Hamid Moayad, D.O., 1305 Airport Freeway, Suite 311, Bedford, Texas, 76021.

Patient or Guardian Signature _____

DR MOAYAD IS AN OUT OF NETWORK PROVIDER FOR PPO INSURANCES

OFFICE POLICY: We appreciate your patronage. The purpose of our policy is to inform patients of their responsibility before their appointment. If you do not understand any part of the policy below, please ask our office staff.

Release of Medical Information:
I hereby authorize Hamid Moayad, D.O., P.A. to furnish information to my insurance carriers, physicians and other facilities concerning my illness and treatments. I certify that I have given correct and complete information with regards to my insurance coverage.

Assignment of Benefits:
I hereby assign Hamid Moayad, D.O., P.A. all payments for medical services rendered. I understand that I am responsible for any amount not paid by my insurance company, including diagnostics services, evaluation, laboratory tests, non-covered services, copays, deductibles, and co insurance balances.

Insurance Policy:
It is the policy of this office to collect copays and deductables at the time of your appointment. It may also be necessary to collect payment in full for some lab services. (Lyme Igenex Testing) that is not covered by insurance.

If for any reasons you cannot pay at the time of service, you may notify the office so we may set up a payment option plan for you. If you do not call the office if you cannot make your appointment, a fee will be applied to that date of service and will be due at your next appointment.

In the event that you give our office out-dated information and payment is subsequently denied or withheld, you are responsible for payment of outstanding balances after an attempt to file the correct information.

Referrals:
If your insurance company requires you to have a referral, it is your responsibility to make sure our office has an active referral at the time of your visit. This includes in network referrals.

General Consent to Treat:
I authorize and direct Hamid Moayad, D. O., P.A. to treat my medical condition in the way they may determine advisable for my well being. I acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the outcome of my treatment.

When you arrive for your visit, date and sign that you understand our office policy, release of medical information, assignment of benefits, referrals, insurance policy, and general consent to treat.

Patient Signature: _____

Guardian Signature: _____

Witness: _____

Lyme Symptom Check List

Patient _____ Birth Date _____

Risk Profile (Please Check)

Infested Area ____ Frequent Outdoor Activities ____
Fishing ____ Hiking ____ Camping ____ Gardening ____ Hunting ____ Ticks Noted on Pets ____
Do you remember being bitten by a tick? No ____ Yes ____ When? _____
Do you remember having the "Bull's Eye Rash"? No ____ Yes ____ Any other rash? No ____ Yes ____

Have you had any of the following? Check all "YES" Answers

Unexplained Skin Changes: Fevers ____ Sweats ____ Chills ____ Flushing ____
Unexplained Weight Change: Weight Loss ____ Weight Gain ____
Fatigue ____ Tiredness ____
Unexplained Hair Loss ____
Swollen Glands ____
Sore Throat ____
Testicular Pain ____ Pelvic Pain ____
Unexplained Menstrual Irregularity ____
Unexplained Milk Production ____ Unexplained Breast Pain ____
Urinary Problems: Irritable Bladder ____ Bladder Dysfunction ____
Sexual Difficulties: Sexual Dysfunction ____ Loss of Libido (desire) ____
Change in Bowel Function: Constipation ____ Diarrhea ____ Upset Stomach ____
Chest Pain ____ Rib Soreness ____
Shortness of Breath ____ Cough ____
Heart Palpations ____ Pulse Skips ____ Heart Block ____
Any history of heart murmur or valve prolapse? Yes ____ No ____
Joint pain or swelling? Yes ____ No ____ List joints: _____
Stiffness: Joints ____ Neck ____ Back ____
Muscle Pain ____ Cramps ____
Twitching: Face ____ Other Muscles _____
Headache ____
Neck Creaks ____ Neck Cracks ____ Neck Stiffness _____
Tingling ____ Numbness ____ Burning _____ Stabbing Sensations ____
Facial Paralysis (Bells Palsy) ____
Eyes/Vision: Double Vision ____ Blurry ____ Pain ____ Increased Floaters ____
Ears/Hearing: Buzzing ____ Ringing ____ Ear Pain ____
Increased Motion Sickness ____ Vertigo ____
Lightheadedness ____ Wooziness ____ Poor Balance ____ Difficulty Walking ____
Tremor ____
Confusion ____ Difficulty Thinking ____
Difficulty with Concentration ____Difficulty Reading ___ Forgetfulness ___ Poor Short Term Memory ___
Disorientation (Getting Lost) ____ Going to Wrong Places ___ Difficulty with Speech ___ Difficulty Writing ___
Mood Swings ____ Irritability ____ Depression ____
Disturbed Sleep: Too Much ____ Too Little ____ Early Awakening ____
Exaggerated Symptoms or Worse Hangover from Alcohol ____

MEDICATION
PATIENT FOLLOW UP FORM

Date: _____ Name: _____

NAME	STRENGTH	FREQUENCY	
1. ANTIBIOTICS:			
			Herxheimers Yes No
_____	_____	_____	Effective Yes No
			Herxheimers Yes No
_____	_____	_____	Effective Yes No
2. PAIN MEDS:			
_____	_____	_____	
_____	_____	_____	
3. ANTI INFLAMMATORY:			
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
4. ANTI DEPRESSANT:			
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
5. ANTI SEIZURE			
_____	_____	_____	
_____	_____	_____	
6. OTHER MEDICATIONS:			
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

LYME PATIENT FOLLOW UP FORM

Date: _____ Name: _____

Please circle on a scale of 0 through 4.
0 being not present and 4 meaning severe symptoms:

	None	Minimal	Mild	Moderate	Severe
1. Chills or mild fever ……	0	1	2	3	4
2. Sore Throat ……	0	1	2	3	4
3. Lymph node pain ……..	0	1	2	3	4
4. Muscle weakness ……	0	1	2	3	4
5. Muscle pain……..	0	1	2	3	4
6. Headaches ……	0	1	2	3	4
7. Joint pain ……	0	1	2	3	4

Specify which joints: _____

_____

Does joint pain move around? Yes ☐ No ☐

8. Neurological symptoms

Light bothers eyes ……	0	1	2	3	4
Forgetfulness ……..	0	1	2	3	4
Irritability ……..	0	1	2	3	4
Confusion; difficulty thinking……..	0	1	2	3	4
Depression ……	0	1	2	3	4
Inability to concentrate ……..	0	1	2	3	4
Brief periods of visual spots or loss of vision..	0	1	2	3	4

9. Sleep disturbance ……	0	1	2	3	4

Too Much ☐ Too Little ☐

10. Fatigue ……..	0	1	2	3	4

Since my last visit I feel: Same ☐ Better ☐ Worse ☐

Patient Comfort Assessment Guide

Name: _____ Date: _____

1. Where is your pain? _____

2. Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle One Occasional Continuous

What time of day is your pain the worst? Circle one.

Morning afternoon evening nighttime

3. Rate your pain by circling the number that best describes your pain at its worst in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Rate your pain by circling the number that best describes your pain at its least in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. Rate your pain by circling the number that best describes your pain at its average in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain right now.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. What makes your pain better? _____

8. What makes your pain worse? _____

9. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

b) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

c) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

d) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

10. What side effects or symptoms are you having? Circle the number that best describes your experience during the past week.

a. Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
b. Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
c. Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
d. Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
e. Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
f. Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
g. Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
h. Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
i. Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
j. Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine

11. Circle the one number that describes how during the past week <u>pain has interfered</u> with your:

a. General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
b. Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
c. Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
d. Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
e. Enjoyment of Life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
f. Ability to Concentrate	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
g. Relations with Other People	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

Purdue: committed to managed care
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HAMID MOAYAD, D.O., P.A.
NEUROLOGY
AMERICAN ACADEMY OF NEUROLOGY
AMERICAN COLLEGE OF NEUROPSYCHIATRY
AMERICAN SOCIETY OF NEUROIMAGING

CONFIDENTIAL
PATIENT AGENDA

Dear Patient:

To help you make best use of your time with Dr. Moayad, please list the questions you would like to discuss during your appointment.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

_____
Signature

_____
Date