# HAMID MOAYAD, D.O., P.A.
# PATIENT REGISTRATION FORM, PLEASE PRINT

Date: _____Date of Birth: _____Age_____ Sex ____Home Number: _____
Name: _____Cell Number: _____
Home Address: _____ Additional Number: _____
City: _____Relationship to Add Number Above: _____
State: _____Zip: _____
Social Security Number# _____Marital Status: M____D____W____S__

**Primary Insurance Company Name**: _____ID #_____
Type of Insurance Policy? Private Insurance: _____ Employer Group Policy: _____
HMO _____PPO _____Indemnity _____POS _____ POS II _____Choice Plus _____EPO_____
Address for Claims: _____
Insurance Phone # for Eligibility: _____
Insured Name: _____ D.O.B. of Insured if not the patient: _____
Insured Employer Name: _____
Policy or Group Number: _____

**Secondary Insurance Company Name**: _____ ID #_____
Type of Insurance Policy? Private Insurance: _____Employer Group Policy:_____
HMO _____PPO _____Indemnity _____POS_____POS II _____Choice Plus _____Plus_____
Address for claims: _____
Phone # for Eligibility: _____
Insured Name: _____ D.O.B. if insured if not the patient: _____
Insured Employer Name: _____
Policy or Group Number: _____

| **Health History** | | **Medical Allergies** | **Medication Taking Now** |
|---|---|---|---|
| High Blood Pressure | Yes ___No ___ | _____ | _____ |
| Diabetes | Yes ___No ___ | _____ | _____ |
| Prolonged Bleeding | Yes ___No ___ | _____ | _____ |
| Easy Bruising | Yes ___No ___ | _____ | _____ |
| Pregnant Now | Yes ___No ___ | _____ | _____ |

**Significant Medical History/ Surgery History** **Reason for Seeking Medical Attention**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I hereby assign all my medical benefits, including Major Medical, 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 are to be made to: **HAMID MOAYAD, D.O., P.A. 2612 HARWOOD RD STE B BEDFORD TEXAS, 76021**

**Patient or Guardian Signature: _____Date_____**

# DR MOAYAD IS AN OUT OF NETWORK PROVIDER FOR PPO INSURANCES ONLY

**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. to release information to my insurance carriers, other physicians and 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. all payments of medical services rendered. I understand that I am responsible for any amount not paid by my insurance company, including diagnostic 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 deductibles at the time of your appointment. It may also be necessary to collect payment in full for some lab services that is not covered by insurance.**

**FIRST INITIAL VISIT FOR PATIENTS PAYING CASH WITH NO INSURANCE:**
**Igenex Lab Testing for Lyme Igg, Igm has to be paid separately by check or credit card made out to Igenex. The check or credit card information will be sent with your lab test the same day. Cash Pay Patients Initial Cost: Your initial cost for an office visit is $400 to $500. Follow up visits will be $200 to $300 and will work with you on payments with an equitable resolution.**

**FIRST INITIAL VISIT FOR PATIENTS WITH INSURANCE:**
**Igenex Lab Testing for Lyme Igg, Igm, has to be paid separately by check or credit card made out to Igenex. Insurance won't cover this test. The check or credit card information will be sent with the lab test the same day. Your Initial visit if you have insurance will be $400 to $500. Follow up visits will be $200 to $300. We will bill your insurance company for your office visit and labs and depending on the reimbursement from your insurance we will work with you on payments with an equitable resolution with deductibles, co-insurance and non-covered services.**

**REFERRALS AND IN-NETWORK APPROVALS:**
**It is the patient's responsibility to keep up with referrals and in network approvals. Dr. Moayad is an out of network provider. If your PPO insurance reimbursement is low we will ask you to help get Dr. Moayad approved to see you at a higher rate of pay and also to keep patient cost down. You will be responsible for keeping up with current approvals for Dr. Moayad to be paid in network with your PPO insurance.**

**GENERAL CONSENT TO TREAT:**
**I authorize and direct Hamid Moayad, D.O., P.A. to treat my medical condition in a way he may determine advisable for my wellbeing. 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, insurance policy. Initial visit for cash patients, Initial visit for patients with insurance Referrals and in network approvals, and general consent to treat.**

**PATIENT SIGNATURE: _____Date: _____**

**GUARDIAN SIGNATURE: _____Date: _____**

**WITNESS FROM DR MOAYADS OFFICE _____ Date: _____**

# 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
   1. Light bothers eyes …….. 0 1 2 3 4
   2. Forgetfulness ……..…….. 0 1 2 3 4
   3. Irritability …….. 0 1 2 3 4
   4. Confusion; difficulty thinking…….. 0 1 2 3 4
   5. Depression ……..…… 0 1 2 3 4
   6. Inability to concentrate …….. 0 1 2 3 4
   7. 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 pain has interfered 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 |

# 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