MARTIN E. MCGONAGLE M.D., P.A.
BOARD CERTIFIED OTOLARYNGOLOGIST
EAR, NOSE, AND THROAT ENDOSCOPIC SURGERY
ALLERGY & SKIN-CANCER-DERMATOLOGY COSMETIC SURGERY

107-B South Park Dr.	510 E. Highway 377	763 N. Graham	107 SW 7th Avenue
Brownwood, Texas 76801	Granbury, Texas 76048	Stephenville, Texas 76401	Mineral Wells, Texas 76067
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325-643-6307 (FAX)	817-579-2663 (FAX)	254-965-5373 (FAX)	940- 327-0177 (FAX)

PATIENT REGISTRATION

DATE: _____ REFERRED BY (PHYSICIAN):_____

PATIENT NAME: _____

STREET ADDRESS: _____

MAILING ADDRESS (IF DIFFERENT) _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH :_____

NAME OF EMPLOYER: _____

WORK PHONE: _____ SPOUSE'S NAME: _____

SPOUSE'S WORK PHONE: _____

In Case of Emergency, please contact: _____

Phone number: _____ Relationship: _____

PLEASE CHECK THE FOLLOWING ITEMS THAT MAY APPLY:

□ MINOR

□ MALE □ FEMALE □ STUDENT □ DISABLED

□ SINGLE □ MARRIED □ WIDOWED □ DIVORCED □ SEPARATED

FOR MINOR CHILDREN:

Guardian Name: _____ Relationship: _____

Address if Different from Above: _____

Home Phone: _____ Work Phone: _____

Social Security #:_____ Date of Birth: _____

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Patient Registration
Insurance & Billing Information

Please provide your insurance cards to our staff so that a copy can be kept with your permanent records.

~ CO-PAYS ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED ~

If you do not have any insurance coverage, charges are due at time services are rendered unless prior arrangements have been made.

1.) INSURANCE COMPANY: _____

ADDRESS: _____

POLICY#: _____ GROUP#: _____

INSURED: _____ SOCIAL SECURITY#: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

2.) INSURANCE COMPANY: _____

ADDRESS: _____

POLICY# : _____ GROUP# _____

INSURED: _____ SOCIAL SECURITY #:_____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

3.) INSURANCE COMPANY: _____

ADDRESS: _____

POLICY#: _____ GROUP#: _____

INSURED: _____ SOCIAL SERCURITY#: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

I hereby authorize direct payment of surgical/medical benefits to Dr. McGonagle for services rendered by him. I understand that I am financially responsible for any balance not covered by Medicare or any other insurance. I also authorize the release of any information pertinent to any insurance company, adjuster, or attorney involved in this case. I authorize Martin E. McGonagle M.D., P.A. to initiate a complaint to the Insuance Commissioner for any reason on my behalf.

Dr. McGonagle accepts all insurance carriers, but is **OUT of NETWORK** for Blue Cross Blue Shield.

Patient Signature or Responsible Party: _____ Date: _____

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HEALTH HISTORY

Patient Name: _____ Birthdate: _____

To help us meet all of you healthcare needs, please fill out both pages of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's Date: _____

Habits:
Smoking (type & amt per day) _____
If former smoker, date quit: _____
Alcohol (type & amt per day) _____
Caffeine (type & amt per day) _____
Street drugs (type & amt per day) _____

Please list all medications you are currently taking (include nonprescription drugs): _____
_____
_____
_____

Please list all serious illness, operations, and other hospitalizations you have experienced and indicate year these occurred: _____
_____
_____
_____

Please list all allergies(foods, drugs, environment)
_____
_____

Chief Compliant: Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing: _____
_____
_____

Family History
Has any blood relative had any of the following: (Check "No" or "Yes", leave blank if uncertain)

	NO	YES	Relationship
Cancer			
Tuberculosis			
Diabetes			
Heart Disease			
Bleeding Tendency			
Stroke			
Epilepsy			
Allergies			
Anemia			
High Blood Pressure			
Asthma			
Chronic Lung Disease			
Drug & Alcohol Problems			
Mental Illness			
Leukemia			
Thyroid Disease			
Ulcer			
Depression			
High Cholesterol			
Kidney Disease			
Glaucoma			

Please continue on next page

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Health History
Page 2

Past Medical History
Have you ever had the following: (Check "No" or "Yes", leave blank if uncertain)

	NO	YES		NO	YES
Measles			Tuberculosis		
Mumps			Diabetes		
Chickenpox			Cancer		
Whooping Cough			Polio		
Scarlet Fever			Glaucoma		
Diphtheria			Hernia		
Smallpox			Lung Disease		
Rheumatic Fever			Asthma/Emphysema		
Heart Disease			Backache		
Arthritis			Stroke		
Thyroid Disease			Nosebleeds		
Anemia			Headaches		
Bladder Infection			Gallstones		
Epilepsy			Hives or Eczema		
Allergies			Mitral Valve prolapse		
Migraine headaches			Ulcer		
Blood or Plasma Transfusions			High/Low Blood Pressure		
Indegestion			Hemorrhoids		
AIDS or HIV+			Bronchitis		
Hepatitis			Blood in Stool		
Kidney Disease			Bleeding Tendency		
Shortness of Breath			Constipation		
Chest Pain			Cough		
Dizziness			Diarrhea		
Change in Bowel Habits			Irregular Heart Beat		
Painful Urination			Venereal Disease		
Vomiting Blood			Swollen painful joints		
Phlebitis			Pneumonia		
Convulsions			Colitis		
Double Vision			Kidney Infection		
Lyme Disease			Swelling of Feet		
Paralysis			Nocturia		
Fainting Spells			Hoarseness		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary healthcare services I (my child) may need.

Parent Signature or Responsible Party:_____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Patient Confirmation Statement

Today I was presented with the NOTICE OF PRIVACY PRACTICES and had the opportunity to read it ask clarification of any portions.

I have retained the noticed for my convenience and referral and hereby sign my acknowledgment of receiving the notice.

HIPPA does not require and accounting of all uses and disclosures of patient information. The following uses and disclosures are not required in an accounting.

Relationship to treatment, payment, healthcare operations

Release of the patient his/herself

Incidental disclosures

National security or intelligence purposes

Correctional facilities

Specifically authorized by the patient

To family or other individuals involved in patient care

Parent Signature or Responsible Party:_____ Date: _____

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PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The practice of Martin E. McGonagle, M.D., P.A. is required by law to protect your private health information and to provide you with this notice of privacy practices. This practice will release minimum information necessary to provide healthcare services for our patient when:

- Filling or re-filling prescriptions
- Obtaining referrals to our practice or another healthcare provider
- Admitting a patient to the hospital
- Providing treatment over the telephone, in person or in written instruction to healthcare providers
- When scheduling appointments and follow-up appointments, procedures or tests by telephone through US Mail or face-to-face discussion
- As necessary to obtain payment from your insurance
- As required by law to report disease, abuse, crime and other public safety/health issues
- To notify you of services or products offered by this practice

The private health information of our patients is held in strictest confidence. No private health information, beyond the minimum necessary outlined above is released to anyone without consent of the patient/guardian of patient.

Patients have the right to obtain a copy of their protected health information, request corrections to this information, have an accounting of the disclosure of their information, and give permission or withhold permission for release of their private health information to any other entity.

Notify the reception desk if there is any concern about release of your private healthcare information in the instances outlined above. You have options for confidential communications. Forms are available at the reception desk at any time for you use.

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you may send a letter outlining your concerns to:

HIPPA OFFICER
Martin E. McGonagle M.D., P.A.

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You will not be penalized or otherwise retaliated against for filing a complaint.
Effective Date : April 15, 2003