Tony McClung M.D.
1213 Hermann Drive #520
Houston, Texas 77004
ph 713 528 3444 www.mcclungclinic.com fx 713 528 4434

PATIENT REGISTRATION FORM

Today's date: | Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:		City:		State:	ZIP Code:
Social Security no.:		Home phone no.: ( )		Cell phone no.: ( )	
Birth date: / /	Age:	Sex: ❑ M ❑ F	Pharmacy Name:		Street your pharmacy is on:
Occupation:	Employer:				Employer phone no.: ( )
Do you have a living will? ❑Yes ❑No	Email Address:				
Do you have power of attorney? ❑Yes ❑No	If yes, person's name:				Phone Number:
Referred to Dr. McClung by (please check one box):		❑ Dr.		❑ Insurance Provider	❑ Hospital
❑ Family	❑ Friend	❑ Website/Internet Search	❑ Yellow Pages	❑ Other	
Spouse's Name (if applicable):				Spouse's Date of Birth:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary insurance:		Group no.:		Policy no.:
Policy Holder's Name:	Birth date: / /	Policy Holder's S.S. no.:		Employer:
Patient's relationship to policy holder:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):		Group no.:		Policy no.:
Policy Holder's Name:	Birth date: / /	Policy Holder's S.S. no.:		Employer:
Patient's relationship to policy holder:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Neil Baum or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Patient Information

Patient's last name: First: Middle: Date of Birth:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who maybe involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________

Signature of Patient or
Legally Responsible Party: ______________________

Relationship to Patient: ______________________

Date: ______________________

Expires one year from date signed

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Tony McClung M.D.
1213 Hermann Drive #520
Houston, Texas 77004
ph 713 528 3444 www.mcclungclinic.com fx 713 528 4434

Patient Release of Medical Records to Dr. Tony McClung

I authorize my medical records to be released and sent to Dr. Tony McClung.

Date: ______________________

Name: ______________________

DOB: ______________________

SSN: ______________________

My Address: ______________________

____

City: __________ State: __________

Zip: __________

Patient Signature: ______________________

Patient Information

Patient's last name: First: Middle: Date of Birth:

RELEASE OF PERSONAL MEDICAL INFORMATION

I, ______________________________, allow the office of Tony McClung, M.D. to discuss my medical information with the following individuals:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

Patient Signature ______________________ Date ______________

Expires one year from date signed.

FOR OFFICE USE ONLY

Date:	Initials of Witness:

Patient Information

Patient's last name: First: Middle: Date of Birth:

Today's Date: ______/______/__________

REASON FOR VISIT TODAY **(Please describe your problem/reason for visit in detail):**

List Relevant Symptoms:

______________________ ______________________

______________________ ______________________

Are you allergic to any medications? (If so please list)

❑ I have no known drug allergies

______________________ ______________________

______________________ ______________________

Are you on any medications? Please List:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Are you taking any blood thinners? (Warfarin) ❑ Aspirin ❑ Plavix ❑ Coumadin

Do you smoke or use tobacco products?

❑ YES ❑ NO If yes, How many packs per day? ______________

For how many years? ______________

Do you drink alcoholic beverages?

❑ YES ❑ NO If yes, How many drinks per day? ______________

Do you drink caffeine (soda, coffee, etc)?

❑ YES ❑ NO If yes, How many drinks per day? ______________

Patient Information

Patient's last name: First: Middle: Date of Birth:

PATIENT PAST MEDICAL HISTORY: (Please list any medical conditions either current or past)

❑ Heart Disease	❑ Heart Attack	❑ Stroke
❑ Diabetes On Insulin? ❑ YES ❑ NO	❑ Cancer (Please specify type)	❑ Hypertension (High Blood Pressure)
❑ High Cholesterol	❑ Prostate Cancer	❑ Depression
❑ Kidney Stones	❑ Kidney Disease	❑ Dialysis
❑ HIV/AIDS	❑ Parkinson's	❑ Alzheimer's
❑ Hepatitis A / B / C	❑ Liver Disease	❑ Epilepsy or Seizures
❑ Other:		

PATIENT SURGICAL HISTORY: (Please list any surgeries you have had and the year they were performed)

Name of Surgery	Date of Surgery (Year)

FAMILY MEDICAL HISTORY: (Please list any medical conditions in your family and specify which family member)

CONDITION	FAMILY MEMBER (mother, father etc)	CONDITION	FAMILY MEMBER (mother, father etc)
❑ Heart Disease		❑ Prostate Cancer	
❑ Diabetes		❑ Cancer Type-	
❑ Stroke		❑ High Cholesterol	
❑ Alzheimer's		❑ Parkinson's	
❑ Heart Attack		❑ Kidney Disease	
❑ High Blood Pressure		❑ Dementia	
❑ Other:			

Patient Information

Patient's last name: First: Middle: Date of Birth:

FEMALE PREGNANCY HISTORY:

Number of Vaginal Deliveries _________ Number of Caesarians _________

Review of Systems

Have you had any of the following problems recently?

GENERAL:
- ❑ Weight loss or gain
- ❑ Fatigue
- ❑ Sleep Apnea
- ❑ Fever or chills
- ❑ Headaches
- ❑ Other: __________

EYES:
- ❑ Blurry or double vision
- ❑ Glaucoma
- ❑ Cataracts

NEUROLOGICAL:
- ❑ Dizziness
- ❑ Numbness/Tingling
- ❑ Seizures
- ❑ Fainting
- ❑ Tremors
- ❑ Paralysis/ Weakness

ENDOCRINE:
- ❑ Excessive Thirst
- ❑ Tired/Sluggish
- ❑ Too Hot/Cold

GASTROINTESTINAL:
- ❑ Abdominal Pain
- ❑ Nausea/Vomiting
- ❑ Stomach Ulcer

CARDIOVASCULAR:
- ❑ Heart Trouble
- ❑ Chest pain or discomfort
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Shortness of Breath
- ❑ Irregular Heart Beat

SKIN:
- ❑ Rash
- ❑ Skin Lumps
- ❑ Psoriasis

MUSCULOSKELETAL:
- ❑ Muscle or joint pain
- ❑ Back Pain
- ❑ Arthritis

EAR/NOSE/THROAT/MOUTH:
- ❑ Sinus Problems
- ❑ Vertigo
- ❑ Hearing loss

RESPIRATORY:
- ❑ Shortness of Breath
- ❑ Frequent Cough
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Coughing up blood
- ❑ Wheezing

HEMATOLOGICAL/LYMPHATIC:
- ❑ Swollen Glands
- ❑ Blood Clotting Problems
- ❑ HIV

PSYCHOLOGIC:
- ❑ Depression
- ❑ Anxiety
- ❑ Suicidal Thoughts