PATIENT INFORMATION SHEET

How did you hear about the Mackie Clinic?/Como se entero de la clinica del Dr. Mackie**? Radio/**Radio____
Newspaper/Periodico____ **Website**/Internet____ **Referral/**Referencia____
Friend,Family/Amigo,Familiar_____ **Church Ad/**Anuncio en la Iglesia____ **Mail/**Correo ____

Patient Name/Nombre del Paciente: ____

Mailing Address/ Direccion de envio: ____ **Apt** ____________

City/Ciudad:_____________________**State**/ Estado:__________**Zip Code**/ Codigo Postal_______________

Home#/Domicilio:_______________**Work#**/Trabajo:_____________**Mobile#**/Cellular:_________________

D.O.B./Fecha de nacimiento: _____________ **Social Security Number**/# del Seguro social_______________

Email/Correo Electronico: ____

(For access to online portal/Para acceso al portal en linea)

Male/Masculino_____ **Female**/Femenino_____

Minor/Menor___ **Single**/Soltero___ **Married**/Casado___ **Divorced**/ Divorciado___ **Widowed**/Viudo___

Separated/Separado___

Preferred language/Idioma preferido**: English**/Ingles____ **Spanish**/Espanol____

Race/Raza: **White**___ **Black or African**___ **Asian**___ **American Indian or Alaska Native**___

Native Hawaiian or other Pacific Islander___ **Patient Declined**/Paciente Rechazo___ **Other/**Otro ___

Ethnicity/Etnicidad: **Hispanic/Latino** Hispano/Latino___**Not Hispanic/Latino** No Hispano/Latino_____

Patient declined/Paciente Rechazo ____ **Other/**Otro ____

If the patient is a minor, who is the parent or legal guardian?/Si el paciente es menor de edad quien es el padre, o tutor legal?

Name/Nombre: _____________________________________ **DOB/**Fecha de Nacimiento**:** ________________

Relationship to patient/Relacion al Paciente: ____________________________________

Phone/Telefono ____________________________________

Emergency Contact/Contacto de Emergencia

Name/Nombre ___________________________________ **Phone**/Telefono ______________________

Relationship to Patient/Relacion al Paciente: ____

Primary Insurance Information/ Informacion del Primer Seguro	**Secondary Insurance Information/** Informacion del Segundo Seguro
Insurance Company/Nombre del Seguro ___________________________________	**Insurance Company**/Nombre del Seguro ___________________________________
Name of Policy Holder/Nombre del Asegurado ____________________________________	**Name of Policy Holder**/Nombre del Asegurado ____________________________________
Address/Direccion ____ ____	**Address**/Direccion ____ ____
OR/O ☐**Same as patient**/Igual al paciente	**OR**/O ☐**Same as patient**/Igual al paciente
Relationship/Relacion _____________________	**Relationship**/Relacion _____________________
DOB/Fecha de Nacimiento _____________________	**DOB**/Fecha de Nacimiento _____________________

AUTHORIZATION AND RELEASE

I authorize the release of any confidential information regarding the diagnosis and the medical records of any treatment or examination of me or my child to my insurance company and/or any other medical provider deemed necessary by the physician. I voluntarily request Dr. Mackie, as my physician, and such associates, technical assistants and other healthcare providers as they may deem necessary, to treat my condition, I hereby assign any medical benefits to Dr. Mackie for services rendered to me and I will be responsible for any amount due to Dr. Mackie that is not paid by my insurance company. I understand that some insurance companies have special requirements and those services such as lab work, hospitalization, audiology services and supplies may not be covered by my plan but are my financial responsibility. I understand that if I do not have insurance and Dr. Mackie accepts me as a private pay patient, I will be responsible for paying for any services I receive at the time of service.

Signature____ **Date** __________________________

If not patient, relationship to patient __________________________

AUTORIZACION Y PERMISO

Autorizo la divulgación de cualquier información confidencial relacionada con el diagnóstico y los registros médicos de cualquier tratamiento o examen de mí o de mi hijo/a a mi compañía de seguros y/o a cualquier otro proveedor médico que el médico considere necesario. Yo voluntariamente solicito al Dr. Mackie, como mi médico, asociados, asistentes técnicos y otros proveedores de cuidado de la salud tratar mi condición, como ellos lo consideren necesario. Por la presente asigno cualquier beneficio médico al Dr. Mackie por los servicios que me han prestado. Entiendo que seré responsable de cualquier cantidad debida al Dr. Mackie que no sea pagada por mi compañía de seguros. Entiendo que algunas compañías de seguros tienen requisitos especiales y que los servicios tales como laboratorios, hospitalizaciones, y servicios de audiología pueden no estar cubiertos por mi seguro, pero son mi responsabilidad. Entiendo que si no tengo seguro y el Dr. Mackie me acepta como paciente, seré responsable de pagar por los servicios que reciba en el momento de servicio.

Firma ____ **Fecha** __________________________

Si no es el Paciente, relacion al Paciente __________________________

Patient Name: _______________________________DOB: _______________Date: _______________

1. **Preferred Pharmacy:please provide name, address, and phone #/** Farmacia de Preferencia:porfavor apunte el nombre, direccion y # de telefono.

2. **List ALL allergies to medications below. If none, please write NONE.**/ Anote todas las alergias a medicamentos.

3. **List ALL current medications you are taking. Include doses, directions, and prescribing doctor.**/ Anote todos los medicamentos que este tomando actualmente. Incluya dosis, instrucciones, y medico que receto.

4. **Surgical History: Please list all surgeries below and year of the surgery.**/ Historia Quirurgica: Anote cirugias previas, incluya año de la cirugia.

5. **List ALL medical conditions you have below (i.e. diabetes, blood pressure, cancer…)/** Anote TODAS las condiciones medicas (por ejemplo, diabetes, alta presion, cancer…)

6. **Smoking History/**Historia de tabaquismo:
   Never smoked/ Nunca fumo
   Smoked x____ years. Quit (year) _______/ Fumo x____años. Dejo de fumar (año) ______
   Currently Smoke _____ packs/weekly x_____ years./ Actualmente fuma ____ cajetillas/semanal x_____ años
   Chew tobacco: YES/NO / Mastica tabaco: SI/NO

7. Alcohol Consumption/Consumo de alcohol:
   None/No toma
   Drinks______ beverages ______ x monthly./ Toma ______ bebidas ______ x al mes.

8. **Family History: List any medical conditions of family members./** Historial familiar: anote cualquier condicion medical de los miembros de la familia.

9. **What is the reason for your visit today?/** Cual es la razon de su visita hoy?

10. **Are you having any of the following symptoms? Please circle all that apply.**/Que sintomas se presentan? Marque todo lo que corresponda.

Clearing of throat/ Desmonte de garganta	**Cough with phlegm**/ Tos con flema	**Difficulty swallowing**/ Dificultad para tragar	**Ear Drainage**/ Drenaje del Oido
Dry Cough/Tos seca	**Dizziness**/Mareos	**Facial Pain**/Dolor facial	**Ear Pain**/ Dolor de Oido
Ear Fullness/Oido Tapado	**Headaches**/ Dolores de Cabeza	**Hearing Loss**/ Perdida de audicion	**Hoarseness**/ Voz Ronca
Itchy/watery eyes/ Comezon o ojos llorosos	**Jaw Pain**/ Dolor de Quijada	**Lump in throat**/ Bultos en cuello/garganta	**Nasal Bleeding**/ Sangrado Nasal
Nasal Congestion/ Congestion Nasal	**Neck Mass**/ Bulto en el cuello	**Post Nasal Drip**/ Goteo Nasal	**Ringing in ears**/ Zumbido en los oidos
Runny Nose/ Escurrimiento Nasal	**Sinus Pressure**/ Presion Nasal	**Skin Rashes**/ Ronchas en la piel	**Sore throat**/ Dolor de garganta
Snoring/Ronquidos	**Sneezing**/Estornudo	**Other**/Otro: ______________________________	

11. **How long have you had these symptoms?/** Cuanto tiempo ha tenido los sintomas?

12. **List ALL the medications you have taken for these symptoms (steroids, antibiotics, antihistamines, & nasal sprays). Please include date of treatment./** Anote todos los medicamentos que ha tomado para estos sintomas (esteroides, antibioticos, antihistaminicos, aerosoles nasals). Porfavor incluya la fecha del tratamiento.

13. **Have you had any imaging studies done for these symptoms? If so, what imaging was done, when, and where?./**Se ha hecho estudios para estos sintomas? Si es asi, que examen fue realizado, cuando y donde?

ASSIGNMENT OF BENEFITS/AUTHORIZATION

I hereby authorize all benefits and payments from my insurance for services provided to be paid directly to The Mackie Clinic. I further understand that I am responsible for any charges not covered by my insurance. I permit a copy of this authorization to be used in place of my original consent and signature. This authorization shall remain valid until revoked in writing. My signature below signifies that I fully understand this statement.

RESPONSIBILITY FOR PAYMENT OF MEDICAL SERVICES

I understand that The Mackie Clinic will file my insurance as a courtesy. However, I am ultimately responsible for all medical fees relating to my care should my insurance deny for any reason such as; authorization, deductible, co-insurance, or non-covered service. I understand that I will be responsible for my bill at the time of service. Other office procedures including but not limited to: audiology exams, phenol, in office ventilation tube, etc. also may not be covered by my office co-pay. My signature below signifies that I fully understand this statement.

HIPPA Notice of Privacy Practices

Acknowledgement of Receipt

My signature below signifies that I have been provided with a copy of the “Notice of Privacy Practices” to read and review and that I fully understand this notice. I understand that I may receive another copy of the Privacy Notice upon request.

____

Signature (patient or responsible party if patient is a minor) Date

**in order to better serve our patients, their families, and comply with federal government’s privacy act we ask that you please list below who you give The Mackie Clinic permission to discuss your medical information with:

____

Name Relationship

____

Name Relationship

____

Name Relationship

Effective Date: May 1, 2016

The Mackie Clinic Appointment Time Policy:

The Mackie Clinic is mindful that everyone's time is important. In doing so, please be advised that there is a **15 minute** window of flexibility for your appointment. If you are running later than that, you have 2 options:

Option 1: Reschedule your appointment for a more convenient time for you

Option 2: You will be worked in at the end of clinic.

The Mackie Clinic strives to be fair and will not penalize those patients that arrive on time.

For those patients that **arrive early**; this **does not** ensure you will be seen early, although we appreciate your punctuality, the appointment time will be honored as much as possible.

Please understand that due to Dr. Mackie being a surgeon/specialist appointment wait times may run later than scheduled.

Please allow a 24 hour notice to cancel or reschedule an appointment. A $30 fee will be charged to no shows.

Thank you for your cooperation.

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The Mackie Clinic es consciente de que el tiempo de todos es importante. Al hacerlo, tenga en cuenta que hay una ventana de **15 minutos** de flexibilidad para su cita. Si está ejecutando más tarde que eso, tiene 2 opciones:

Opcion 1: Vuelva a programar su cita para un momento más conveniente para usted.

Opcion 2: Lo veremos al final de la clinica.

The Mackie Clinic se esfuerza por ser justo y no penalizar a los pacientes que llegan a tiempo.

Para aquellos pacientes que **llegan temprano**; Esto **no asegura** que se le vea temprano, aunque apreciamos su puntualidad, el tiempo de cita será honrado lo más posible.

Por favor, comprenda que debido a que el Dr. Mackie es un cirujano/especialista, los tiempos de espera pueden ser más tarde de lo programado.

Por favor, permita un aviso de 24 horas para cancelar o reprogramar una cita. De lo contrario se cobrara una quota de $30.

Gracias por su cooperación

______________________________________ ________________________

Signature/Firma **Date/Fecha**

Eugene S. Mackie M.D.
2401 Cornerstone Blvd. Edinburg, TX 78539
Phone (956) 631-2957 Fax (956) 631-1983

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _________________________________ **Date of Birth:** ______________
Nombre del Paciente *Fecha de Nacimiento*
Social Security #: _____________________________________
Numero Del Seguro Social

I request and authorize that my medical records be released to **The Mackie Clinic** for medical purposes pertaining to my medical treatment with **Dr. Eugene S. Mackie**.

Solicito y autorizo que mis expedientes medicos sean transferidos a ***The Mackie Clinic*** *para propositos medicos relacionados con mi tratamiento medico con* ***Dr. Eugene S. Mackie****.*

Requesting medical records from:

Family/Doctor Name: ____

Address: ____

City: ____________________________ State: _____________ Zip Code: _______________

Phone: ________________________________ Fax: ________________________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

____

☐ All healthcare information

☐ Other: ____

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. □ Yes □ No

Patient/Guardian Signature: ________________________________ Date: _________________
Firma del Paciente/Guardian *Fecha*

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED