William R. McKenna, M.D., P.A.
DIPLOMATE, AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY
CLINICAL ASSOCIATE PROFESSOR, UT HEALTH SCIENCE CENTER AT SAN ANTONIO

Patient's Name : _____ **Age:** _____

Referring Dr : _____ **Date:** _____

Chief Complaints: (Circle your main symptoms)

Head/Nose Symptoms

a. Sneezing
b. Nasal congestion
c. Runny nose
d. Colored mucus
e. Post nasal drip
f. Hoarseness
g. Sinus pressure/pain
h. Eyes: itchy / red / watery
i. Ears: itchy / blocked / popping
j. Headache

Age of Onset:_____

Head/Nose symptoms are:
Year round
Spring / Summer
Winter / Fall

Chest Symptoms

a. Cough
b. Wheezing
c. Shortness of breath
d. Chest congestion
e. Chest tightness
f. Chest pain

Severity:
Intermittent / Mild
Moderate / Severe

Age of Onset:_____

Chest symptoms are:
Year round
Spring / Summer
Winter / Fall

Skin Symptoms

a. Urticaria
b. Hives
c. Swelling
d. Rash
e. Dryness
f. Eczema

Severity:
Intermittent / Mild
Moderate / Severe

Age of Onset:_____

Location of Skin Symptoms
All over / Head / Trunk
Upper / Lower extremities
Genital Area

Do you note any increase in symptoms from any of the following? (Please circle all that apply)

a. Aggravating Factors/ Allergies
None Noticed
Cut grass
Hay
Feathers
Smoke
House Dust
Dogs
Cats
Insect Stings
Weather Changes
Windy days
Damp weather
Strong odors / Perfumes

b. Aggravating Factors/Asthma
None Noticed
Nasal sinus symptoms
Exercise / Going up flight of stairs
Smoke
Perfumes
Strong odors
Dogs/Cats
House Dust
Cut grass
Weather changes
Damp/Humid weather
Stress/Anxiety
Acid Reflux

c. Aggravating Factors/Skin
Unknown
Rash
Itchy
Exertion
Sweating
Hot/Cold weather
Medication
Foods
Stress

Foods **(List):**_____
_____

Past Medical History:

Cancer: Breast/ Prostate/Other_____

Heart Disease: Hypertension/Cholestrol/Other_____

ENT: Glaucoma/Hearing Loss/Sinus Problems/Other_____

Skin: Eczema/Skin disease/Other_____

Musculoskeletal: Arthritis/Other_____

Endocrine/Renal: Diabetes/Thyroid/Other_____

GI: GERD/Hiatal Hernia/Other_____

GU: Prostate/GYN problems/Other_____

Respiratory: Asthma/COPD/TB/Chronic Cough/Other_____

Neurological: Epilepsy/Seizures/Chronic Headaches/Other_____

Psych/Social: Depression/Anxiety/Other_____

Surgical History/Procedures:

Cardiac : Artery-Bypass/Other _____

ENT : Eyes/Ears/Sinus/Septoplasty/Tonsillectomy/Other_____

Lung : Broncoscopy/Other_____

Musculoskeletal: Back/Knee/Foot/Other_____

Endocrine/Renal: Thyroid/Other_____

GI surgery: Appendectomy/Hernia/Other_____

GU surgery: Prostate/Other_____

GYN surgery: Mastectomy/Hysterectomy/Other_____

Other: _____

Family History: Allergies / Asthma _____

Allergy/Asthma/Nasal Sprays Medication: **All Other Medications:**

_____

_____

_____

_____

_____

Are you allergic to any Medication/Drugs?_____

Can you tolerate Aspirin/Ibuprofen? (Motrin/Advil)_____

Had Previous allergy testing ? YES / NO Name of Doctor:_____

Testing Year?_____ **Received allergy injections? YES / NO How many years?**_____

Smoking History: Current smoker/ Former smoker/ Never/Passive smoker. Year started____ **Year Quit**_____

Home Conditions: Age of pillow _____ **Mattress** _____ **Carpet** _____ **Sofa: Cloth / Leather** _____

Do you have pets at the home? Cats / Dogs / Other _____ **Indoor / Outdoor**

Radiology Study Type: Chest X-ray / CT Scan sinus / Other _____

Radiology results: Normal / Abnormal Date Done:_____

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Referente Medico:_____ **Fecha:**_____

Nobre del Paciente:_____ **Edad:**_____

Principales Quejas: (Circule las sintomas pricipales)

Sintomas de Cabeza/Nariz

a. Estronudos
b. Congestio nasal
c. Rinorrea
d. Color de moco
e. Goteo postnasal
f. Ronquera
g. Senos Presion/dolor
h. Ojos: picazon/rojos/llorosos
i. Oidos: picazon
j. Dolor de cabeza

Edad de Inicio:_____

Las epocas peor :
Todo el ano
Primavera / Verano
Inverno / Otono

Irritantes de Alergias

Desconocido
Cesped cortado
Heno
Plumas
Polvo de casa
Peros/ gatos
Picadura de Insectos
Cambios de clima
Dias ventosos
Olores Fuertes / Perfumes

Sintomas de Pecho

a. Toz
b. Sibilancias
c. Falta de respiracion
d. Congestion en el pecho
e. Opresion en el pecho
f. Dolor del pecho

Gravedad:
Intermitente/Leve
Moderado/Severo

Edad de Inicio:_____

Las epocas peor:
Todo el Ano
Primavera / Verano
Inverno / Otono

Irritanates de Asma

Desconocido
Ejercicio/escalones
Humo
Perfumes
Oloros fuertes
Peros / gatos
Polvo de casa
Cesped cortado
Clima humeda
Estres / Ansieda

Sintomas de la Piel

a. Urticaria
b. Picazon
c. Hinchazon
d. Erupcion
e. Resequeda
f. Eczema

Gravedad:
Intrermitente/Leve
Moderado/Severo

Edad de Inicio:_____

Las epocas peor:
Todo el Ano
Primavera / Verano
Inverno / Otono

Irritantes de la Piel

Desconocido
Erupcion
Picazon
Ejercicio
Climas caliente / frio
Medicamentos
Alimentos
Estres

Lista de Alimentos:_____

Enfermedas:

Cancer: Pecho/ Prostata/ Otro_____
Heart Disease: Hipertension/ Colestrol/ Otro_____
ENT: Glaucoma/ Perdida de Audicion/ Problemas Sinusales/ Otro_____
Skin: Eczema/ Enfermedad de la Piel/ Otro_____
Musculoskeletal: Arthritis/ Otro_____
Endocrine/Renal: Diabetes/ Tiroides/ Otro_____
GI: GERD/ Hernia Hiatal/Otro_____
GU: Prostata/ Ginecologo/ Otro_____
Respiratory: Asma/COPD/ Tuberculosis/ Otro_____
Neurological: Epilepsia/ Convulsiones/ Otro_____
Psych/Social: Depresion/ Anxiedad/ Otro_____

Historia Quirurgico/ Procedimientos:
Cardiaco : Bypasss de Arteria/ Otro_____
ENT: Ojos/Oidos/Senos/Septoplastia/Amigdalectomia/Otro_____
Pulmon: Broncoscopia/ Otro_____
Musculoesqueletico: Espalda/ Rodilla/Pie/Otro_____
Endocrino/Renal: Tiroides/Otro_____
GI Cirugia: Apendectomia/ Hernia/Otro_____
GU Cirugia : Prostata/Otro_____
GYN Cirugia: Mastectomia/ Histerectomia_____
Otro: _____

Medicamentos para Alergia/Asma/Aerosoles Nasales: **Otros Medicamentos:**

_____
_____
_____
_____
_____

? Es usted alergico a alguna Droga?_____
? Puede usted tolerar la aspirina y el ibuprofen (Motrin/ Advil)?_____
? A tiendo pruebas de alergia antes? Si/ No Nobre del Medico ?_____
? En que ano?_____ **Recibio vacunas? Si / No Por cuanto tiempo?**_____
Historia de Fumar: Actual fumador/ Fumador pasado/ Nunca fumo Ano iniciado_____**Ano dejo de fumar**_____
Tipo de estudio de Radiografia: Pecho / Tomografia Computarizada de los Senos
Tienen mascotas en la casa? Gatos / Peros / Otro _____ **Adentro / Afuera**
Cuales fueron los resultados? Normal / Anormal Fecha:_____

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Harlingen, Texas 78550
(956) 425-9240

REGISTRATION
(Please Print)

Date_____

Email Address: _____ Home Phone_____
Cell Phone _____

Patient's Last Name_____ First Name_____ Middle Name_____
Street Address_____
Mailing Address_____
City _____ State_____ Zip code_____ Social Security #_____
Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By_____
Business Address_____
Occupation _____ Business Phone_____

Responsible Party _____ Relationship to patient_____
Birthdate_____ Social Security #_____ Phone Number_____
Street Address_____
Mailing Address_____
Employer_____ Business Phone_____
Business Address_____ Occupation_____

Preferred Pharmacy: _____
Emergency Contact: _____
Emergency Contact Phone number: _____

Do you have Medical Insurance? ☐ Yes ☐ No ☐ Medicare ☐ Medicaid ID:_____
Name of Primary Insurance Company_____
Name of Primary Insured_____
Subscriber #_____ Group #_____

Name of Secondary Insurance Company_____
Name of Secondary Insured_____
Subscriber #_____ Group #_____

How did you learn of our practice? _____
Do you have siblings/relatives that are patients of Dr. McKenna? _____
Did a physician refer you? If yes, please list the doctor's name. _____

ASSIGNMENT and RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to William R. McKenna, MD all medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to William R. McKenna, MD for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

Revised 07/04

Acknowledgement of receipt of Notice of Privacy Practices: This notice is effective on: April 14, 2003

Please sign your name and print your name on this acknowledgement form. Return your signed acknowledgement to the receptionist.

Signature_____
Printed Name_____
Date_____

This notice is effective on: April 14, 2003

William R. McKenna, MD PA

PROVIDER NOTICE
OF PRIVACY PRACTICES

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

Uses and disclosures of health information

We use health information about you for treatment, to obtain for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop future uses and disclosures.

We may change our policies at any time. Before we make a significant change to our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes and other than when you explicitly authorize it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. The person listed below can provide you the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

If you have any questions or complaints, please contact:
Office Manager: Linda McKenna
Address: 1713 Treasure Hills Blvd, Ste 1-B
Harlingen, Texas 78550
Phone: (956) 425-9240

Consent to Check Medication History

I understand that the practice will be electronically reviewing my medication history. This will include my history over the last 2 years regarding medications filled at the pharmacy. I understand this is for my personal medical record and used for my safety. I understand this information will be confidential unless waived by express and informed consent by me or my legally authorized substitute decision-maker.

_____

Patient Name

_____

Patient or Legal Representative Signature

_____

Date