Mason Park Medical Clinic
21770 Kingsland Blvd
Katy, Texas 77450

Phone Number: 281-646-0740
Fax Number: 281-646-0743
Family Practice

Patient Information

First Name: _____ Last Name:_____

Sex: Male / Female **Date of Birth: _____** (MM/DD/YYYY)

Social Security: _____ (### - ## - #####)

Contact Information

Cell Phone: _____ Work Phone: _____

Email:_____ (Online Medical Records/Portal Access)

Street Address_____

City: _____ State: _____ Zip Code: _____

Insurance Information

Insurance Company: _____ Effective Date: _____

Insurance ID: _____ Insurance Group: _____

Guarantor Information

First Name: _____ Last Name: _____

Sex: Male / Female **Date of Birth: _____** (MM/DD/YYYY)

Social Security: _____ Patient Relation: Spouse / Child / Other

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

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Pharmacy Information

Name (Location): _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Medication & Substance History

#	Name of Medicine	Dosage	#	Name of Medicine	Dosage
1			6		
2			7		
3			8		
4			9		
5			10		

Smoking Status: Never / Former / Recreational / Heavy

Sexual Orientation: Heterosexual / Homosexual / Bisexual / Decline to Specify

Drug Allergies: _____

Food Allergies: _____

Emergency Contact

Full Name: _____

Phone Number: _____

Relationship:_____

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Medical History

Please check or list any major illness that YOU have:

☐ Tuberculosis	☐ Diabetes Mellitus	☐ Kidney Disease	☐ Breast Cancer
☐ Emphysema	☐ Thyroid Disease	☐ Epilepsy	☐ Ovarian Cancer
☐ Heart Disease	☐ Anemia	☐ Neurological Disorder	☐ Colon Cancer
☐ High Blood Pressure	☐ Hemophilia	☐ Liver Disease	☐ Prostate Cancer
☐ Osteoporosis	☐ _____		☐ _____

Please indicate any surgeries you have had and the year you had them done:

Surgery	Year	Surgery	Year	Surgery	Year	Surgery	Year
Angioplasty		Trauma Related Surgery		Stomach Surgery		Tubal Ligation	
SurgeryCarotid Artery		Back or Neck Surgery		Inguinal Hernia		C-Section	
Other Vascular Surgery		Hip Surgery		Colonoscopy		Hysterectomy	
Coronary Bypass Surgery		Knee Surgery		Gallbladder		Ovary Removed	
Chest/Lung Surgery		Carpal Tunnel Surgery		Appendectomy		Breast Surgery	
Tonsillectomy		Sinus Surgery		Prostate Surgery		Thyroid Surgery	
Neurosurgery		Ear Surgery		Bladder Surgery		Other: _____	

Please indicate when you had any of the following preventative tests or services:

Preventative Tests	Year	Preventative Tests	Year	Preventative Tests	Year	Preventative Tests	Year
Cardiac Angiogram		Flu Vaccine		Prostate Cancer Blood Test		Mammogram/Breast Exam	
Stress Test		Pneumonia Vaccine		Rectal Exam		PapSmear	
Echocardiogram		Tetanus Vaccine		Colon Cancer Stool Test		Date of Last Physical	
Chest X-Ray		Hepatitis Vaccine		Flexible Sigmoidoscopy		Other:_____	
EKG		Bone Density Test		Barium Enema			

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Acknowledgment of Receipt: Mason Park Medical Clinic Agreements

Mason Park Medical Clinic reserves the right to modify the privacy practices outlined.
I have read and reviewed the "*Mason Park Medical Clinic Notice of Privacy Policies"*
I have read and reviewed the "Mason Park Medical Clinic Consent Form"
I have read and reviewed the "Mason Park Medical Clinic Authorization Form"

_____
Patient Name (Printed)

_____
Signature of Patient

_____
Guarantor Printed Name

_____
Representative Signature (If Patient a Minor)

_____ _____
Date (MM/DD/YYYY) *Representative Relation*

PERMISSION TO RELEASE INFORMATION

Below we will discuss the approved forms of contact regarding appointments, results, and/or any other information regarding your treatment here at *Mason Park Medical Clinic;* as well as who is deemed an allowed person of communication regarding the above.

Person(s) of Contact			
Name			
Phone Number			
Relationship			