Tri Cities
Family Medicine

PATIENT INFORMATION SHEET

Patient Information: Birth Date_____ Age_____

Last Name_____ First Name_____ Middle Int_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone _____

Male_____ Female_____ Patient Social Security#_____

Patient Driver's License#_____ Email_____

Work Phone_____ Marital Status_____ Student Status_____

Employer_____ Employment Status_____

Referring Physician_____ Ethnicity (optional)_____ Preferred Language (optional)_____ Race (optional)_____

Responsible Party Information:

Last Name_____ First Name_____ Middle Int_____

Address_____

Date of Birth_____ Phone #_____ Social Security #_____

Insurance Information:

Primary Coverage_____ Policy #_____ Group #_____

Insured's Name_____ Date of Birth_____

SS# of Insured_____ Relationship to Patient_____

Secondary Coverage_____

Date of Birth_____ Insured's Name_____ Relationship to patient_____

Emergency Contact_____ Phone #_____ Relationship to patient_____

Reason for visit:_____ Preferred Pharmacy_____

I have completed this form fully and certify that I am the patient or authorized agent of the patient, authorized to furnish all the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered.

I hereby assign to the above named doctor all benefits, rights, and proceeds for services rendered under any insurance policies or any reimbursement or prepaid health care plans. I hereby authorize the release of pertinent information to insurance carriers and agree to pay all charges incurred.

Signature_____ Date_____

REVISED MAY 2016

NAME_____ DOB_____

FAMILY HISTORY

	Disease	Onset Age	Died at age, if app'l
Father:			
Mother:			
Sister:			
Brother:			
Paternal Grandmother:			
Paternal Grandfather:			
Maternal Grandmother:			
Maternal Grandfather:			

(Use back of sheet if necessary)

NAME: _____ **DOB:** _____

PAST MEDICAL HISTORY (cont)

Seizures ___
Serious illness or injuries ___
Shortness of Breath ___
Sleep Apnea ___
Sleep disorder ___
Tuberculosis ___
Ulcers ___
Urinary Tract Infections ___
Urologic disorders ___

List ALL other providers you are currently seeing:

Name:	Specialty:
_____	_____
_____	_____
_____	_____

(Use back of sheet if necessary)

List ALL previous surgeries:

Date of Surgery:	Type of Surgery:	Place of Surgery:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Use back of sheet if necessary)

Tri Cities
Family Medicine

123 Ranch House Road, Willow Park, TX 76008
Phone: (817) 984-7120 Fax: (817) 984-7121

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name (s): _____ Social Security #: _____

I, _____ (Your Name), request and authorize _____ (Doctor or Hospital)
to release healthcare information of the patient named above to:

Name: Tri Cities Family Medicine

Address: 123 South Ranch House Rd

City: Willow Park State: Texas Zip Code: 76008

This request and authorization applies to:

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

_____

☐ All Healthcare Information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

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

Patient and/or Representative Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective July 20, 2015), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please be specific):

Employee Signature Date

_____

Medical Information Release Form
(HIPAA Release Form)

I AGREE IN THE EVENT A FAMILY MEMBER OR CAREGIVER ATTENDS MY OFFICE VISIT AND IS IN THE EXAM ROOM AT THE TIME OF THE EVALUATION AND/OR TREATMENT, I GIVE TRI CITIES URGENT CARE AND ITS PROVIDERS AND EMPLOYEES MY PERMISION TO DISCUS FREELY MY CONDITION, TREATMENT, OR DIAGNOSIS WITH THE PERSON PRESENT.

Circle one: I agree or I don't agree

Patient Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Parent_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date:____/____/____

REVISED MAY 2016

PATIENT CLINICAL INTAKE FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

DATE OF VISIT: _____

DESCRIBE YOUR MAIN CONCERN TODAY: _____

PAST MEDICAL HISTORY:

Other: _____
ADD or ADHD ___
Allergies___
Anemia ___
Anxiety Disorder ___
Aortic Aneurysm ___
Arrhythmia ___
Arthritis ___
Asthma ___
Atrial Fib ___
Back Pain ___
Bedwetting ___
Birth defects/Inherited disease ___
Bleeding disorder ___
Blood clots ___
Breast Cancer ___
CAD ___
COPD ___
CVA/Stroke___
Cancer ___
Chest Pain ___
Chicken Pox ___
Claustrophobic ___
Congenital Heart Disease ___
Congestive Heart Failure ___
Constipation ___
Depression ___
Developmental/Behavioral disorders ___
Diabetes ___
Dialysis ___
Diverticulitis ___
Ear or Hearing Problems ___
Eczema, hives, or other skin conditions ___
Endometriosis ___
Epilepsy ___
Eye problems ___
Fibromyalgia ___
GERD ___
Gastrointestinal disease ___
Genitourinary disease ___
Gout ___
HIV or AIDS ___
Head Trauma ___
Headaches/Migraines ___
Heart Disease ___
Heart Problems ___
Heart Valve Disorder ___
Heart Murmur ___
Hemophilia ___
Hepatitis ___
Hernia ___
Hiatal Hernia ___
High Cholesterol ____
High Blood Pressure ___
Hyperthyroidism ___
Hypothyroidism ____
Joint Pain ___
Kidney Disease ___
Kidney Stones ____
Leg or Foot Ulcers ___
Liver Disease ___
Obesity ___
Organ transplant ___
Osteoarthritis ___
Osteoporosis ___
Osteopenia ___
Pacemaker
Pulmonary Embolism ___
Rheumatoid Arthritis ____

Sexually transmitted disease history:	Yes	No
At risk for Hep B:	Yes	No
At risk for Hep C:	Yes	No
At risk for TB:	Yes	No
Passive Smoke Exposure:	Yes	No
Family History of Heart Disease:	Yes	No
(Before Age 50?)	Yes	No

I, _____, DECLINE TO ANSWER THE QUESTIONS IN THE ABOVE SECTION. DATE: _____

FEMALE PATIENTS ONLY:

Last Menstrual Period:	_____		Unknown
Frequency of Cycle:	_____		
Menses monthly:	Yes	No	
Age of Menarche:	_____		
Prior Hysterectomy:	_____		
Current Birth Control:	_____		
If post menopausal/age of menopause:	_____		
Date of last PAP:	_____		
# of child births:	_____		
# of pregnancies:	_____		
# of vaginal births:	_____		
# of cesarean births:	_____		
Complications:	Yes	No	

Please explain: _____

Preventative History

Last Check Up/Physical/PAP:	_____	
Last Blood Work:	_____	
Were you fasting for blood work:	Yes	No
Last EKG:	_____	
Last Chest Xray:	_____	
Last Mammogram:	_____	
Last Bone Mineral Density:	_____	
Last Colonoscopy:	_____	
Last Vision Screening:	_____	
Last Dental Exam:	_____	

NAME: _____ **DOB:** _____

SOCIAL HISTORY

Smoking Status: (Circle One) Never Former Current Every Day Current Some Day
How Much: _____ **packs per day**
Tobacco – Years of Use _____
Smokeless/Chewing Tobacco : YES or NO
How many cans per day: ____

Please place an "X" in the appropriate column

	None	Occasional	Moderate	Heavy
Alcohol Intake				
Caffeine Intake				
Exercise Level				
Stress Level				

Alcohol – How many years of use: _____

Diet:

Regular	Specific
Vegetarian	Low Carbohydrate
Vegan	Gluten Free
Cardiac Diet	

Marital Status: _____

****THE FOLLOWING QUESTIONS ARE REQUESTED BY INSURANCE COMPANIES. IF YOU WISH TO NOT ANSWER, PLEASE SIGN AND DATE AT THE END OF THIS SECTION**.***

Sexual Orientation: Heterosexual Homosexual Bisexual

Sunscreen Used routinely: Yes No
Smoke alarm in home: Yes No

Sporting Activities: _____

Education (select last level completed):

Less than 8th Grade	High School Graduate
9th Grade	2 year College
10th Grade	4 year College
11th Grade	Post Graduate

Sexually active: Yes No

Diabetic Patients ONLY:

Last Diabetic Foot Exam: _____

Last Diabetic Eye Exam: _____

MEDICATION HISTORY:

Allergies:

Please list any allergies or adverse reaction:

Drug/Allergen	Reaction	Onset Date

(Please use back of sheet if necessary)

_____ NKDA (No known allergies)

MEDICATIONS:

List ALL medications you are currently taking, how often, the dosage and reason

Name	Dosage	Directions	Reason

(Please use back of sheet if necessary)

General Consent to Treatment:

Having come to _____ (Provider) for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize the Provider and other staff members involved in my care to administer such diagnostic procedures, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the Provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggested examination, test or treatment.

Right to Refuse Treatment:

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care professional. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Patient Signature: _____ Date: _____
Printed Name: _____

Parent/Legal Guardian Signature: _____ Date: _____
Printed Name Parent/Legal Guardian: _____

Witness Signature: _____ Date: _____
Printed Name Witness: _____

PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING)

I have been made aware and understand that the medical practices and office may utilize electronic prescription systems which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medication I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Patient Signature: _____ Date: _____
Patient Printed Name: _____

Witness Signature: _____ Date: _____
Witness Printed Name: _____

MEDICATION PRESCRIPTION POLICY AND AGREEMENT

The following is an outline of our medication prescription refill policy here at Tri Cities Family Medicine.

1. If you need a refill on your medication, we ask that you call your pharmacy and tell them which medication you need refilled. They, in turn, will fax or call us with all the information we need to refill the medication. **If you call us, we will ask that you call the pharmacy.**

2. We do not refill any medication after business hours or on the weekends. Our provider(s) do not have access to your medical records after business hours. Please make sure you contact your pharmacy at least 3 days before you run out of the medication to allow time for the refill to be processed. **Any calls for medications received after 4:30 PM will not be addressed until the following business day.**

3. Tri Cities Family Medicine does **NOT** write/prescribe **ANY CONTROLLED** medications. For example but not limited to (Hydrocodone, Codeine, Xanax, Clonazepam, Temazepam, Ambien, Lunesta, Soma, Morphine, Oxycontin, Percocet, Testosterone Gels/Creams/Injections, Adderall, Concerta, Ritalin, Vyvanse).

AFTER BUSINESS HOURS, WEEKENDS AND HOLIDAYS

Our normal business hours are 8 AM to 12 PM and 1 PM to 6 PM, Monday through Thursday. We are closed on major holidays. In case of an emergency, a life threatening situation, or concerning symptoms, please call 911 or go to the nearest emergency room or urgent care.

Our providers do not have access to your medical records after business hours, weekends or holidays. If you would like to schedule an appointment, please call during normal business hours.

I have read and understood the above policies (pages 8 & 9) and agree to adhere to the policies.

Patient Signature: _____ Date: _____
Printed Name: _____

Parent/Legal Guardian Signature: _____ Date: _____
Parent/Legal Guardian Printed Name: _____

Witness Signature: _____ Date: _____
Witness Printed Name: _____