Texas Familicare Medical Group
1725 Chadwick Court, Suite 100
Hurst, Texas 76054

PATIENT INFORMATION

Date: _____-_____-____

Name: _____ Birth date: _____-_____-_____ Age _____ Sex: M/F

Address: _____ City:_____ State:_____ Zip: _____

Home Phone# ( )_____ Work Phone# ( )_____ Cell Phone#_____

Social Security#_____-_____-_____ Driver's License #_____ State _____

Preferred contact method: Phone call/Voicemail _____ Email _____

If email please provide email address: _____

Marital Status: (circle one) Single, Married, Divorced, or Widowed

Employer: _____Address:_____

Patient's Occupation: _____

Name of Spouse: _____ Birth date: ____-____- ____

Spouse's Employer:_____Address_____

Spouse's Occupation: _____

Spouse's Work Phone#: _____ Spouse's Cell Phone#: _____

Emergency Contact: _____ Relationship: _____ Phone#:_____

Reason for Office Visit: _____

If changing Physician: Name, Address and Phone #_____

Primary Insurance: _____ Insured's Name: _____

Group #: _____Member #:_____ Birth date: _____-_____-_____

Secondary Insurance: _____ Insured's Name: _____

Group #: _____ Member#: _____ Birth date: _____-_____-_____

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes I am responsible for all physician charges and non-covered medical services.

Patient's Signature: _____ Date: _____

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Patients Name:_____DOB : _____ Today's Date:_____

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING
PLEASE CIRCLE AND INDICATE WHICH RELATIVE: M, F, B, S, GM, GF

1)	EPILEPSY	6) THYROID DISEASE	11) OSTEOPOROSIS	16) LIPID DISORDER
2)	MIGRAINES	7) HAYFEVER	12) ARTHRITIS	17) ALCOHOLISM
3)	MENTAL ILLNESS	8) ASTHMA	13) HEART DISEASE	18) HEPATITIS
4)	GLAUCOMA	9) ANEMIA	14) STROKE	19) CANCER
5)	DIABETES	10) BLEEDS EASILY	15) HYPERTENSION	20) OTHER_____

PATIENT'S MEDICAL HISTORY

HOSPITAL ADMISSIONS (NOT INCLUDING PREGNANCIES)

YEAR	ILLNESS OR OPERATIONS

LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING:
NAME, DOSAGE AND FREQUENCY

1) _____6)_____
2)_____ 7)_____
3)_____ 8)_____
4) _____ 9)_____
5) _____10)_____

Pharmacy Name:_____
Pharmacy Number: _____
Pharmacy Address/Cross Street: _____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING: CIRCLE

EAR INFECTION-FREQUENT	CONVULSIONS	SKIN DISORDER
EYE PAIN	NOSE BLEEDS-RECURRENT	MRSA
FAILING VISION	ABDOMINAL PAIN	TUBERCULOSIS
DOUBLE OR BLURRED VISION	APPENDICITIS	ANOREXIA
DECREASED HEARING	DIVERTICULOSIS/CROHN'S/COLITIS	
FRACTURE OR DISLOCATION	ANEMIA	BLOOD IN URINE
HEAD INJURY	BLOOD DISORDER	SUGAR IN URINE
NECK INJURY	ASTHMA/WHEEZING	DIABETES
ARM INJURY	BRONCHITIS	BLOODY OR TARRY STOOL
HAND OR WRIST INJURY	CHRONIC COUGH	DIARRHEA/CONSTIPATION
SHOULDER INJURY	ALLERGIES/HAY FEVER	KIDNEY PROBLEM
ELBOW INJURY	SINUS TROUBLE	HERNIA
RIB INJURY	SORE THROAT-FREQUENT	STOMACH ULCER
BACK INJURY	RHEUMATIC FEVER	CANCER
LEG INJURY	HEART TROUBLE	TUMOR / CYST
FOOT OR ANKLE INJURY	CHEST PAIN	ARTHRITIS
MUSCLE DISORDER	HIGH BLOOD PRESSURE	OSTEOMYELLITIS
AIDS/HIV POSITIVE	HEADACHES	MYALGIA
ALCOHOLISM	DIZZY SPELLS	NEURITIS
DRUG ADDICTION	FAINTING SPELLS	VERICOSE VEINS
VENEREAL DISEASE	DIFFICULTY SWALLOWING	HARDENING OF ARTERIES
EPILEPSY	NERVOUS DISORDER	

TEST / EXAM	YEAR
RECTAL / STOOL	
FASTING LABS	
EYE EXAM	
PSA / MALE EXAM	
COLONOSCOPY	
VACCINES	**YEAR**
TETANUS / TD	
INFLUENZA (FLU)	
PNEUMONIA	
HEPATITIS	
TUBERCULOSIS	
FEMALE	**YEAR**
WELL WOMENS EXAM	
MAMMOGRAM	
PREGNANCIES	
CHILDREN	
FOOD OR DRUG	**ALLERGIES**
SMOKE START	Y / N STOPPED
DRINK ALCOHOL START	Y / N STOPPED

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HIPPA NOTICE

This notice describes how we may use and disclose your medical information and how you can access this information. Please review this notice carefully.
Once you sign the consent for Texas Familicare Medical Group, we may use and disclose your medical information to treat you, to obtain payment and to operate the practice.
Examples of use and disclosures for treatment:

*If the physician or nurse practitioners refer you for a cardiac stress test and needs to call the cardiologist for results, the physician or nurse practitioners may give your name and the reason for ordering the stress test to the cardiologist's office.
*The physician or nurse practitioner at the practice may call you to advise you of treatment alternatives

Examples of use and disclosures to obtain payment:

*The practice's billing office may submit a claim form that contains your name, address, social security number, diagnoses, and procedures performed in our office, to your insurance company.

Examples of use and disclosures to operate the practice:

*The physician and nurse practitioner may audit (read and or comment upon) your chart to track and improve our performance in assuring that we perform screening test and immunizations on time.
*The practice staff may leave a message on your telephone and ask you to return our call.
*The practice staff may mail you reminders of upcoming appointments.

The practice may use or disclose protected health information about you for other purposes, and without your consent, if the law requires us to disclose information to government authorities.
Examples of such uses or disclosures include:

*Suspected abuse and infectious diseases.

You have the following rights regarding your protected health information and the practice must act on your request within 60 days:

*You may request restrictions on certain uses and disclosures of protected health information, but we are not required to agree to a request restrictions.
*You may request that you receive confidential communication of protected health information.
*You may request that your information be amended.
*You may request a paper copy of this notice.

The law requires the practice to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices.
The law requires the practice to abide by the terms of this notice and to provide individuals with notice revisions.
You may complain to the practice to the U.S Department of Health & Human Services if you believe your privacy rights have been violated. File a complaint with the practice by writing to:
Texas Familicare Medical Group, 1725 Chadwick Court Ste. 100, Hurst Texas 76054.
No one will retaliate against you for filling a complaint.

_____ _____
Patient Signature Date

Texas Familicare Medical Group
1725 Chadwick Court, Suite 100
Hurst, Texas 76054

I understand that Robert Strzinek, Ph.D., D.O., Sharon Fowler N.P., and Sara Toler N.P., may need to use and disclose privacy information about my health or medical problems for the purposes of arranging, conducting, or referring my treatment; for obtaining payment for services; and for operating the practice. I consent to the use of my privacy information for the purposes of treatment, payments, and health care operations.

I understand that my consent is not needed if the law requires Robert Strzinek, Ph.D., D.O., Sharon Fowler N.P., and Sara Toler N.P., to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease, or potential for serious bodily harm to myself and others).

I understand that I have the right to review the privacy notice Robert Strzinek, Ph.D., D.O., Sharon Fowler N.P., and Sara Toler N.P., to request restrictions on the use of my information, and to revoke my consent at later date.

I understand that if I withhold consent to the use of my information for the purposes of treatment, payment or operations, Robert Strzinek, Ph.D., D.O., Sharon Fowler N.P., and Sara Toler N.P., may refuse to undertake my care.

This authorization is effective on the date signed and continues through the duration of my association with this practice, unless revoked in writing.

_____ (initials) I acknowledge that I have received a copy of this Office's Notice of Privacy Practices.

_____ _____ _____
Signature Print Name Date

On the line below, please list any persons (for example, relatives) to whom your medical information may be released. (If you prefer no one have access to your medical information, please write **no one** on the line below).

_____

ID required? _____ _____
YES NO

(Please understand, if you choose YES Robert Strzinek, Ph.D., D.O., Sharon Fowler N.P., and Sara Toler N.P., will not be allowed to talk to these people over the phone, they must come into the office & show identification).

May we leave a message on your answering machine? _____ _____
YES NO

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ _____,
(Patient's Name) (Date of birth)

(Consent and authorize the release of my records from: Include Name, Address, City & State)

_____

PHONE#_____FAX #_____
(Hospital or Physician(s)

(Release to) Texas FamiliCare Medical Group, Robert A. Strzinek PhD. D.O.

(Address) 1725 Chadwick Court, Suite 100, Hurst, TX 76054

(Information to be released)_____

I authorize the release of any information contained in the above records including treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or IUV-related conditions.

_____ (Individual or personal rep.'s initials)

These records are required for the following purpose: PCP/Continued Care

Signature_____ Date_____
(Patient or legal representative)