JIRCIK
MEDICAL GROUP

FRANK P. JIRCIK, MD
PRECIOUS J. MARQUART, MD
AARON MITSCHKE, FNP
JESSICA NELSON, FNP

Last Name:_____

First Name:_____

Middle Name/suffix:_____

Preferred Name:_____

Legal Sex:_____ DOB:____/____/_____

SSN:_____

Address:_____

_____

City:_____ St:_____ Zip:_____

Cell:(_____)_____-_____

Home:(_____) _____-_____ _____

Language:_____ Race:_____

Marital status: _____

Guardian Name: _____

Employers Name: _____

Ph:(_____)_____-_____

Retired: _____

Reason for today's visit? _____

_____

Emergency contact:_____

Phone:(_____)_____-_____

Relationship:_____

Insurance company Name:_____

_____

Address:_____

_____

Phone:(_____)_____-_____

Policy holder Name:_____

Dob:___/___/_____ Relationship:____

Member ID:_____

Group:_____

Local Pharmacy:_____

Phone:(_____)_____-_____

Mail order pharmacy:_____

Phone:(_____)_____-_____

Patient Email : _____

_____

Would You like access to the portal?____

How did you hear about us?_____

Don't forget to like us on facebook!

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SOCIAL HISTORY:

Tobacco smoking status: Never Smoked **Previously Smoked** **Current Smoker**
Declined **How many packs per day** _____ **per week** _____
Smokeless Tobacco Status: Never Smoked **Previously Smoked** **Current User**
E-Cigarette/vape Status: Never Used **Previously Used** **Current User**
Number of years of use _____

GYNECOLOGICAL HISTORY: For Woman only

Date of last Pap smear: ____/____/_____
If Post-Menopausal, age at menopause:
Sexually active: Yes/ No
Sexual Issues: Yes/ No
Age at first child: ____
Current birth control:

Recent Mammogram: ____/____/_____
Date LMP: ____/____/_____
Flow: Normal/ Abnormal
Duration of flow: _____ **days**
Age at menarche:
Menses Monthly: Yes/ No

Are you interested in getting on a form of birth control? Yes/ No

FAMILY HISTORY: Please indicate if there is a family history of the following conditions

Member:	Living or Deceased	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer
Mother:						
Father:						
Siblings:						
Maternal: Grandmother						
Maternal: Grandfather						
Paternal: Grandmother						
Paternal: Grandfather						
Daughter:						
Son:						

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VACCINATIONS: For Children please include most recent record:

FLU: Yes/ No Date: ___/___/____ PNEUMONIA: Yes/ No Date: ___/___/____

SHINGLES: Yes/ No Date: ___/___/____ Other: Date: ___/___/____

Problems:

ADHD: Yes/ No
Anemia: Yes/ No
Cancer: Yes/ No Type:
Diarrhea: Yes/ No
Depression: Yes/ No
GERD: Yes/ No
Heart Disease: Yes/ No
Hypertension: Yes/ No
Pacemaker: Yes/ No
Stroke: Yes/ No
AIDS/HIV: Yes/ No
Anxiety: Yes/ No
Cataracts: Yes/ No
Urinary Issues: Yes/ No
Diabetes: Yes/ No
Glaucoma: Yes/ No
Hemorrhoids: Yes/ No
High Cholesterol: Yes/ No
Prostate Issues: Yes/ No
Thyroid Disorder: Yes/ No

Alcoholism: Yes/ No
Arthritis: Yes/ No
Chest Pain: Yes/ No
COPD: Yes/ No
Emphysema: Yes/ No
Eczema: Yes/ No
Gout: Yes/ No
Hepatitis: Yes/ No
Kidney Disease: Yes/ No
Mental Illness: Yes/ No
Tuberculosis: Yes/ No
Alzheimer's Disease: Yes/ No
Asthma: Yes/ No
Constipation: Yes/ No
Defibrillator: Yes/ No
Epilepsy/ Seizure: Yes/ No
Headaches/Migraines: Yes/ No
Hernia: Yes/ No
STD: Yes/ No
Non-prescription Drugs: Yes/ No

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PATIENT CARE TEAM: Please list any specialist you see regularly:

Doctors Name:	Speciality:	Location:

PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

Medication:	Reaction:	Severity:

LIST ALL MEDICATIONS:

Medication:	Strength:	Directions:

Surgical History: Please list all previous surgeries and dates:

Medication History Authority: Yes/ No

Patients Name: _____

Date of screening: _____

Temperature (at arrival): _____

Visitor Name: _____ Temp: _____

Regardless of your vaccination status, have you experienced any of the symptoms in the list below in the past 48 hours?

	VISITOR:
• Fever or chills: YES/ NO	YES/ NO
• Cough: YES/ NO	YES/ NO
• shortness of breath or difficulty breathing: YES/ NO	YES/ NO
• Fatigue: YES/ NO	YES/ NO
• muscle or body aches: YES/ NO	YES/ NO
• Headache: YES/ NO	YES/ NO
• new loss of taste or smell: YES/ NO	YES/ NO
• sore throat: YES/ NO	YES/ NO
• congestion or runny nose: YES/ NO	YES/ NO
• nausea or vomiting: YES/ NO	YES/ NO
• Diarrhea: YES/ NO	YES/ NO
• Hospitalized in the last 14 days: YES/ NO	YES/ NO
• Tested for covid in the last 14 days: YES/ NO	YES/ NO

RESULTS:	RESULTS:
• Exposed to covid in the last 10 days: YES/ NO	YES/ NO
• Are you vaccinated: YES/ NO	

Patient screened to come in person: YES/ NO

Screened By: _____

Fall Prevention Balance and Dizziness SL..

Patient Name: _____ **Age:** _____ **Date:** _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer.	**Yes or Often**	**Some-times**	**No or Never**
1. Do you ever lose your balance or feel dizzy or unsteady?			
2. Have you continued to experience dizziness after an injury or accident?			
3. Do you feel unsteady when you are walking or climbing stairs?			
4. Do you feel dizzy while sitting down or rising from a seated or lying position?			
5. Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?			
6. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
7 Are you dizzy or unsteady when you first get up in the morning?			
8. Do you ever fall or feel like you are about to fall for no apparent reason?			
9. Do you use a walker, cane, or any other form of assistance for your mobility?			
10. Have you had a recent loss of, or decrease in, your vision or hearing?			
11. Do you fear falling?			
12. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
13. Has your balance problem caused problems in your social life?			
14. Have you fallen more than once in the past year without an obvious cause?			
15 Does dizziness or imbalance interfere with your job or your household responsibilities?			

Please provide this to your physician during your visit.

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Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

Social History

Date:_____

Tobacco smoking status

Never Smoker	Former Smoker	Current every day smoker
Current some day smoker	Smoker- Status unknown	Unknown if ever smoked
Not indicated	Not tolerated	Refuse to answer

Smoking - how much

1 pack per week	2 packs per week	¼ pack per day	½ pack per day
1 pack per day	1 ½ pack per day	2 pack per day	3+ pack per day

Smokeless tobacco status

Never used smokeless tobacco	Former smokeless tobacco user	Current snuff user
Currently chews tobacco	Currently uses moist powdered tobacco	Not indicated

Tobacco-years of use

E-Cigarette/Vape status

Never used E-Cigarette/Vape	Former E-Cigarette/Vape user	Current E-Cigarette/Vape user

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URINARY INCONTINENCE ASSESSMENT

This survey is designed to determine if the patient is has bladder control/incontinence issues.

Patient Name:	DOB:	Date:

Are you experiencing any issues with any of the following conditions:		
☐ back or pelvic injury	☐ Diabetes	☐ diuretic use
☐ stroke or pelvic injury	☐ obesity	☐ history of bladder surgery
☐ nerve disorder	☐ BPH	☐ frequent UTIs in the last 90 days

☐ How frequently do you urinate	☐ 1-4 times daily ☐ 5-9 times daily ☐ >10 times daily
☐ How many times do you get up during the night to urinate?	☐ 1-3 times nightly ☐ 5 or more times nightly
☐ In the past 6 months, have you accidently leaked urine?	☐ NO ☐ Yes
☐ Do you currently use absorbent products for urine leakage (adult diapers, pads, bed liners, protective undergarments?)	☐ NO ☐ Yes
☐ Are there obstacles that prevent you from getting to the bathroom on time (physical, structural, mechanical)? If yes explain: _____	☐ NO ☐ Yes
☐ There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem?	☐ NO ☐ Yes

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9) DATE:_____

PATIENT NAME: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use x to indicate your answer in the column)

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERYDAY
	(0)	(1)	(2)	(3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3 Trouble falling asleep, staying asleep, or sleeping to much				
4. Feeling tired or having no energy				
5. Poor appetite, or over eating				
6. Feeling bad about yourself, or that you have let yourself or family down				
7. Trouble concentrating, staying focused				
8. Moving or speaking slowly, or feeling restless				
9 Thoughts that you would be better dead, or hurting yourself in some way				
ADD Columns:	+	+	+	+
Total:				

If you marked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with others?

Not difficult at all _____
Somewhat difficult _____
Very Difficult _____
Extremely Difficult _____

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Medical Record Release Form

Last name _____ Address _____

First name _____ City _____

Middle name _____ State

DOB _____ ZIP code _____

SSN _____ Phone Number _____

By signing this form, I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me:

Person/Organization to Release Information:

Doctor or Facility Name _____ Address _____

Phone Number _____ City, State _____

Fax Number _____ ZIP code _____

Person/Organization to Receive Information:
Jircik Medical Group
12001 South Freeway, Suite 304 Burleson, Texas 76028
Office 817-551-5400 Fax 817-568-0961

Health information that relates to service beginning from _____ to _____, may be released:

- Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
- Patient Histories • Test Results
- Office Notes (except psychotherapy notes)
- Radiology Studies • Films
- Referrals • Consults • Billing Records
- HIV-Related Treatment
- Insurance Records • Genetic Testing
- Records Sent by Other Health Care Providers I further understand that my medical record may include one or more of the following:
- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- Mental Health Information or Psychological Conditions • Alcohol or Substance Abuse Treatment

_____

Signature of Patient, legal guardian or patient's representative Date

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HIPPA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW.

Dr. Jircik's office will maintain a record of the care and services you receive at our practice. this consent only covers your protected health information created while you are a patient at our pratice. Your protected information pertains to your diagnosis and/or treatment at our practice, including but not limited to information concerning mental illness,use of alcohol or drugs or communicable diseases such as Human immunodeficiency virus ("HIV"), and acquired Immune deficiency syndrome("AIDS"),laboratory test results, medical history,treatment progress or any other such related information.
Our Notice of Privacy Practices provides information about how our practice and its physicians may use and/or disclose protected health information about your treatment,payment,healthcare operations and as otherwise allowed by law. Our office reserves the right to change our policies and make new provisions effective for all PHI we maintain. We will update you of any changes that may occur. If you feel that your privacy has been violated, you may file a complaint with us or with the Office of Civil Rights, US Dept of Health and Human Services.
Secretary of Health & Human Services
RegionVI, Office for Civil Rights
US Dept of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing. You will NOT be penalized for filing a complaint.

By signing this form, you acknowledge receipt of a copy of our Notice of Privacy Practices, and that you had the opportunity to review it before signing this consent.

You have the right to request us to restrict how we use and disclose your protected information for the purpose of treatment, payment or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request ,we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

_____

Signature of Patient, Legal guardian or Patients Representative Date

_____

Signature of Witness Date

JIRCIK
PERRY A. JIRCIK, M.D., P.C.

Frank P. Jircik, MD
Precious J. Marquart, MD
Aaron Mikschke, FNP
Jessica L Nelson, APRN

Release of Information:

Health information that relates to service beginning from

_____ to _____, may be released:

May be released to: _____

Relationship: _____

Phone : (_____) _____-_____

Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.

- Patient Histories • Test Results
- Office Notes (except psychotherapy notes)
- Radiology Studies • Films
- Referrals • Consults • Billing Records
- HIV-Related Treatment

- Insurance Records • Genetic Testing
- Records Sent by Other Health Care Providers I further understand that my medical record may include one or more of the following:
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Signature of Patient, legal guardian or patient's representative Date

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