James R Bond Jr., M.D., P.A.
1615 Lancaster Dr. Suite 107
Grapevine, TX 76051
817-488-5555

Date: _____

Patient Name: _____ DOB: _____

Address: _____

Phone Number: _____

Email: _____

Please list ALL Current Medications and/or Vitamins/Supplements:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

****** THIS FORM MUST BE FILLED OUT YEARLY ******

James R Bond, Jr., M.D., P.A.
1615 Lancaster, Drive Suite 107
Grapevine, TX 76051
817-488-5555
Fax: 817-421-0400

Disclosure of Medical/Financial Information to Friends or Family
(For Patients 18 years and older)

Name of Patient: _____

Date of Birth: _____ Phone Number: _____

Email: _____

I, the undersigned, hereby authorize Dr. James R. Bond, Jr. and staff to disclose information from my medical or financial record to the following people:

Name: _____ Relationship: _____

Phone Number: _____

Type of information (circle): Medical Financial Both

_____

Name: _____Relationship: _____

Phone Number: _____

Type of Information (circle): Medical Financial Both

This authorization is given freely with the understanding that:

1. This authorization is valid between January through December of year signed.
2. May revoked in writing at any time but not retroactively.
3. The facility, its employees, officers, and physician are hereby released from any legal responsibility of liability for disclosure of the information I authorized previously.

_____ _____

Patient Signature or Authorized Representative Date

James R Bond, J.R., M.D., P.A.
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*******FOR ALL OUR PATIENTS 65 YEARS OLD AND OLDER*******

Name: _____

Address: _____

Phone #: _____ DOB: _____

Email: _____

Have you received the pneumonia vaccine? Yes No

Have you received the flu vaccine in the last year? Yes No

Do you have a living will? Yes No

Which statement best reflects your wishes on advanced care recommendations?

_____Do Not Intubate: I do not wish to have a breathing tube even if it is necessary to save my life.

_____Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

_____Full Cardiopulmonary Resuscitation. I want full cardiopulmonary resuscitation efforts to be made.

Primary Care Doctor or Family Doctor: **(Please provide name and phone #)**

_____

Who in your family or household can make medical decisions in case of an emergency? Please give name and phone number:

_____

_____ _____

Signature Date

Updated 6-22-22