JIRCIK
MEDICAL GROUP

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!

JIRCIK

MEDICAL GROUP

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:						

JIRCIK

MEDICAL GROUP

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

JIRCIK
MEDICAL GROUP

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

JIRCIK

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:
- 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

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.

JIRCIK
MEDICAL GROUP

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 prolected 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
MEDICAL GROUP

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

Nurse Practitioner / Physician Assistant

Consent for Treatment

Dr. Frank Jircik currently has on staff a Nurse Practitioner and/or a Physician Assistant to assist in the delivery of primary medical care.

A Nurse Practitioner is not a doctor. A Nurse Practitioner (NP) is a registered nurse who has completed specific advanced nursing education (generally a master's degree or doctoral degree) and training and can diagnose, treat, and monitor common acute and chronic diseases, as well as provide health maintenance care. In addition, the NP may treat minor lacerations and other minor injuries.

A Physician Assistant is not a doctor. A Physician Assistant (PA) is a healthcare professional trained and licensed to practice medicine with limited supervision of a physician. A Physician Assistant is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of health care services that are traditionally performed by a physician. Physician Assistants conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, and write prescriptions. In addition, the PA may treat minor lacerations and other minor injuries, as well as perform surgical procedures.

I have read the above and hereby consent to the services of Nurse Practitioner or Physician Assistant for my health care needs.

I understand that at any time I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician.

_____ _____

Patient Name Date of Birth

_____ _____

Patient / Guardian Signature Date