Texas Physicians Primary Care

Family Practice

2100 Virginia Drive, Suite D, Grand Prairie, TX 75051

Phone: 972-264-2331

Fax: 972-264-2333

Email: GrandPrairieClinic@tbmso.net

Pediatrics/Family Practice

502 W. Kearney St, Suite 700, Mesquite, TX, 75149

Phone: 972-288-7337

Fax: 972-289-9076

Email: MesquiteClinic@tbmso.net

Pediatrics

9812 Lakeview Pkwy, Rowlett, TX, 75088

Phone: 972-463-7327

Fax: 972-463-7004

Email: RockwallClinic@tbmso.net

Patient Information Sheet

Patient Name: _____ DOB: _____

Address: _____

City, State & Zip Code: _____ SS#: _____

Home #: _____ Work #: _____ Cell #: _____

Employer Information

Employer's Name: _____ Phone #: _____

Address: _____

Emergency Contact

Name: _____ Relationship: _____

Phone #: _____

Insurance Information

(If you have a secondary insurance, Please advise the receptionist, Thank you)

Name of Insurance: _____ Insured's DOB: _____

Member ID/Policy #: _____ Group #: _____

SS# of insured: _____ Name of insured: _____

Relationship to insured: (Please circle one) Self Spouse Child

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I authorize TPPC Providers to release medical information that may be necessary to request reimbursement by my insurance company to who I have submitted claims. I understand I am responsible for all medical fees during my treatment with TPPC Providers. If surgery is required, I assign all medical and/or surgical benefits to which I am entitled to TPPC Providers. This assignment will remain in effect until revoked by me in writing. A photocopy or assignment is to be considered as valid as an original. I understand and overpayment on my account will be promptly refunded.

Signature: _____ Date: _____

REVISED: 01/02/2017

My Medication List

Name:_____ DOB:_____

Drug Allergies:_____

_____

Pharmacy:_____ Phone:_____

Medication	Strength	How Often?	Comments

REMEMBER TO UPDATE YOUR MEDICATIONS

Mark out medications that are discontinued

REVISED: 01/02/2017

Texas Physicians Primary Care, PLLC

Patient Preferences Regarding Communication of Patient Health Information (PHI)

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **Patient** or **Legal Guardians**.

If you would like to add additional contacts (other than the patient or legal guardian) that Texas Physicians Primary Care is allowed to disclose this type of information to. Please complete the fields below and select the appropriate spaces based on your approval for the person you list.

Contact Name: _____ Relationship to patient:_____

_____ Billing Account Information _____ Medical Condition Information

If your preferred method of communication is by phone please indicate below (Please check one):

___ Leave a message with detailed information.
___ Leave a message with a call-back number only.
___ Authorizing medical staff to discuss my diagnostic test results with me personally by phone.

Patient Secure Messaging
Use of Electronic Communication from Texas Physicians Primary Care to the Patient.

___**Yes,** I want Texas Physicians Primary Care to communicate my information with me through a secure system that is designed to keep information safe.

*You will be notified via e-mail when there is information for you to review. Please PRINT in the space below the e-mail address you would like to use to receive secure messages.

E-mail address:_____

___**No,** I do not want Texas Physicians Primary Care to use electronic communication as a way to communicate my information to me.

Consent and Agreement

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communications from Texas Physicians Primary Care. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Signature of patient or Legal guardian Date

REVISED: 01/02/2017

Print Form

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient name:_____Date of Birth_____

Address:_____

Phone Number:_____Treatment dates from:_____to_____

I authorize: (enter your current physician's information)

_____

_____

_____

To release copies of my medical records to: (enter your new physician)

_____

_____

_____

I authorize release of information of the following portions of my medical record:

_____Mental Health
_____Substance Abuse
_____All
_____HIV/AIDS
_____Communicable Disease
_____Only the following:_____

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release _____ from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (or legal representative)_____Date:_____

Relationship to Patient:_____Witness:_____

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of thezzerson to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.