OFFICE HOURS AND AFTER HOURS MESSAGES

Our office is open:

ORANGE	**BEAUMONT**
Monday 8am-5pm	8am-5pm
Tuesday 8am-5pm	8am-5pm
Wednesday 8am-6pm	8am-5pm
Thursday 8am-5pm	8am-5pm
Friday 8am-4pm	8am-3pm

If you have a medical emergency after hours, please report to the nearest Emergency Room. Medication refills and appointment requests are addressed only during business hours. Phone calls for refills and appointment requests will not be returned after hours. If you require urgent assistance after hours, please call our main office number:

Beaumont 409-832-3377

Orange 409-920-4223

Your call will be answered by an answering service who will provide the message to the nurse on call. Please allow one hour for your call to be returned. If your call has not been returned within one, please notify the answering service again.

Thank you,

Triangle Area Network Staff

Welcome To Our Office!

How can we help you today? Please select one of the following: Primary Care Visit ___ Lab Services ___

HIV/Hep C Testing____ Series 7 Testing___ Other (please explain) ________________________________

Name (First, M.I, Last): ____________________________________ Preferred Name: ________________

Which facility are you wanting to be seen at? Beaumont or Orange (circle one)

Date of Birth: ___/___/______ SSN: ______-______-________ Gender(circle): M/F/Identifies as ______

Home Address: ____

City: _________________________________ State: _______________________ Zip Code: ___________

Primary Phone: (_____)_________________________ Secondary Phone: (_____)__________________

Employer: ____ Work Phone: (_____)__________________

Employer's Address: ____

City: ______________________________ State:_________________ Zip Code: ________________

Complete this section ONLY if someone other than the patient is financially responsible.

Responsible Party: _______________________________ Relationship to Patient: ____________________

Date of Birth: ____/____/________ Social Security Number: _______-_______-__________

Home Address: ____

City: _________________________________ State: _______________________ Zip Code: ___________

Primary Phone: (_____)_________________________ Secondary Phone: (_____)__________________

Employer: ____ Work Phone: (_____)__________________

Employer's Address: ____

City: ______________________________ State:_________________ Zip Code: ________________

In case of an emergency, contact: ______________________________ Relationship: __________________

Primary Phone: (_____) _________________________ Secondary Phone: (_____) __________________

Insurance Information

Patients Name: ______________________________ Today's Date: ________________

Primary Insurance

Name of Insurance Company: ____

Insured's Name: ___________________________ Date of Birth: ______________________

Policy ID Number: ____________________________________ Group Number: ______________

Secondary Insurance

Name of Insurance Company: ____

Insured's Name: ___________________________ Date of Birth: ______________________

Policy ID Number: ____________________________________ Group Number: ______________

Our office will file with your insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts.

Initial __________ I authorize the release of any medical information necessary to process my claim.

Initial __________ I understand I have to notify my providers office within 3 business days if my insurance changes or cancels.

Initial __________ I understand my copayment is due at time of visit.

Signature of Patient/Legal Guardian: ____

Date: ______________________________

Patient Health History

Check box of any symptoms you have or have had in the past year

General

- [ ] Chills/Fever
- [ ] Depression/Nervousness
- [ ] Dizziness/Fainting
- [ ] Forgetfulness
- [ ] Headache
- [ ] Loss of sleep
- [ ] Loss of weight
- [ ] Numbnes s
- [ ] Sweats

Pain, weakness, numbness in:

- [ ] Arms
- [ ] Back
- [ ] Feet
- [ ] Hands
- [ ] Hips
- [ ] Legs
- [ ] Neck/Shoulders

Genito-Urinary

- [ ] Frequent Urination
- [ ] Lack of bladder control
- [ ] Painful urination

Cardiovascular

- [ ] Chest Pain
- [ ] High/Low Blood Pressure
- [ ] Irregular/Rapid heart beat
- [ ] Poor circulation
- [ ] Swelling of ankles
- [ ] Varicose veins

Gastrointestinal

- [ ] Poor appetite
- [ ] Bloating
- [ ] Bowel changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive thirst
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Nausea
- [ ] Rectal Bleeding
- [ ] Stomach pain
- [ ] Vomiting
- [ ] Vomiting blood

Skin

- [ ] Bruise easily
- [ ] Hives
- [ ] Itching/Rash
- [ ] Change in moles
- [ ] Sores that won't heal

Eye, Ear, Nose, Throat

- [ ] Bleeding gums
- [ ] Blurred vision
- [ ] Difficulty Swallowing
- [ ] Double vision
- [ ] Earache/ear discharge
- [ ] Hoarseness
- [ ] Loss of hearing
- [ ] Nosebleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Sinus Problems
- [ ] Vision - Flashes/Halos

MEN ONLY

- [ ] Erection difficulties
- [ ] Lumps/Irregularity in testicles
- [ ] Penis discharge
- [ ] Sore on penis

WOMEN ONLY

- [ ] Abnormal Pap Smear
- [ ] Bleeding between cycles
- [ ] Breast lump/tenderness
- [ ] Extreme menstrual pain
- [ ] Hot flashes
- [ ] Nipple discharge
- [ ] Painful intercourse
- [ ] Vaginal discharge

Date of LMP ______________

Year of last pap smear ________

Last mammogram ___________

Social Habits

Smoke: Yes or No

If yes: how many packs per day____

Alcohol: Yes or No

If yes: how many drinks per day ____

Street Drugs: ______________________

Patient Health History

Check box of any symptoms you have or have had in the past year

☐	HIV/AIDS	☐	Kidney Disease
☐	Appendicitis	☐	Liver Disease
☐	Arthritis	☐	Measles
☐	Asthma	☐	Migraines
☐	Bleeding Disorders	☐	Multiple Sclerosis
☐	Breast Lump	☐	Mumps
☐	Cancer	☐	Pacemaker
☐	Cataracts	☐	Pneumonia
☐	Chemical Dependency	☐	Polio
☐	Chicken Pox	☐	Prostate Problem
☐	Diabetes	☐	Rheumatic Fever
☐	Emphysema	☐	Scarlet Fever
☐	Epilepsy	☐	Stroke
☐	Glaucoma	☐	Thyroid Problems
☐	Heart Disease	☐	Tuberculosis
☐	Hepatitis	☐	Ulcers
☐	Herpes	☐	Venereal Disease
☐	High Cholesterol	☐	Other ___________

Please list if any of your immediate family has had any of the following:

	Condition	Family Member
☐	Heart Disease/Attack	
☐	Stroke	
☐	Diabetes	
☐	High Blood Pressure	
☐	High Cholesterol	
☐	Thyroid Disease	
☐	Depression	
☐	Other Mental Illness	
☐	Alcoholism	
☐	Asthma	

	Condition	Family Member
☐	Osteoporosis	
☐	Migraines	
☐	Breast Cancer	
☐	Colon Cancer	
☐	Prostate Cancer	
☐	Lung Cancer	
☐	Ovarian Cancer	
☐	Uterine Cancer	
☐	Skin Cancer	
☐	Other ___________________	

Medication List

Please list ALL medications, including other prescribing doctors, over the counter medications, and vitamins/supplements.

Prescribing Doctor	Medication Name	Dosage	How often	Start Date

PREFERRED LOCAL PHARMACY: ______________________________

PREFERRED MAIL ORDER PHARMACY: ______________________________

Please be advised ALL new medications and refills will be called out after 3:00pm

Please list ALL allergies:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ____ to release to:

Triangle Area Network
1495 North 7th Street
Beaumont, TX 77702
Fax: 877-547-8271

Triangle Area Network Orange
3737 N 16th St
Orange, TX 77632
Fax: 888-910-2061

The information of the medical records on:

Patient Name______________________________ SS#___________________________

Admit/Treatment Date: ____________________ Birthdate:______________________

I hereby authorize the release of the following information, including, if applicable, any treatment or test results for alcohol and/or drug abuse, or reportable communicable diseases, including acquired immune deficiency syndrome or human immuno-deficiency virus infection.

__Inpatient data:____

__Outpatient data: ____

__Emergency report: ____

The above information is released/requested for medical assessment only purpose, and that purpose only. Any other use is forbidden.

I also understand that I may revoke, in writing, this authorization at any time but not retroactive to the release of information made in good faith.

This authorization will expire one year from the date of my signature.

Patient Signature:___________________________________ Date:_____________________