TAN
A Southeast Texas Community Health Center

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

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