



Today's date: PCP: Tamara T. Kurmanalieva, MD

PATIENT INFORMATION

Patient's last name: First: Middle: Marital status (circle one)
Sin Mar Sep Div Wid Minor

E-mail address Birth date: Age: Sex:
M F

Street address: Apt: City: State: Zip:

S.S. no.: Home phone no.: Cell phone no.: Work:

Guardian Name:

Street address: Apt: City: State: Zip:

Referred to clinic by: Family Friend Online Other

INSURANCE INFORMATION

(Please give your insurance card and a picture ID to the receptionist.)

Is this patient covered by insurance? Yes No Type of Insurance: PPO

Please indicate primary insurance Blue Cross Blue Shield Blue Cross Blue Shield Other

Subscriber's name: Subscriber's S.S. no.: Birth date: Subscriber's ID no.: (Not a Group no.) Co-payment:
Effective date: \$

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative not living with you: Relationship to patient: Home phone no.: Cell phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Tumesh for Optimal Health. I also authorize Tumesh for Optimal Health to release any information required to process my claims for related services to my insurance company.

I understand that all co-payments, co-insurance, and/or deductibles are due at the time of service. I understand that I am financially responsible for any balance. - NO EXCEPTIONS.

It is my responsibility to inform this office of any charges in my insurance coverage. This office DOES NOT verify benefits at the time of service. I am responsible for knowing my benefits and will be responsible for contacting my insurance carrier for details. I will be financially responsible for all services rendered that are NOT covered or paid by my insurance plan.

I hereby acknowledge that I have read and understood that the Notice of Privacy Practices of Tumesh for Optimal Health before filling out all required forms. I further acknowledge that a copy of any amended Notice of Privacy practices will be available at each appointment at the front desk and online at www.tumesh.com

Patient/Guardian signature

Date

Tumesh for Optimal Health  
**MEDICAL HISTORY INFORMATION**

Name of Patient: \_\_\_\_\_

Reason for the Visit: \_\_\_\_\_

Health goals: 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Are you allergic to any medications? No Yes If yes, list medications and reactions:

Medication	Reaction

Do you take any medications daily? No Yes if yes, please list medications and dosage:

Medication	Dosage	Nutritional Supplements	Dosage

**HEALTH HISTORY** List all your known medical conditions:


Have you ever had chicken pox?  No  Yes If yes, approximately what year? \_\_\_\_\_

**SURGERY/INJURY** List previous surgeries or injuries and approximate year

Surgery	Year	Injury (Trauma or Fractures)	Year

**FAMILY HISTORY** List family member and approximate age of onset:

Disease	Family Member	Age of Onset
Thyroid Disease		
Strokes		
Seizures		
Osteoporosis		
High Cholesterol		
High Blood Pressure		
Heart Disease/ Heart Attacks		
Diabetes/ Adult or Juvenile Onset?		
Depression		
Cancer/ What type?		
Blood Disorder		
Alcoholism		

**SOCIAL HISTORY**

Are you married?  Yes  No # of children \_\_\_\_\_ Boys: \_\_\_\_\_ Girls: \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ Problems: \_\_\_\_\_

Circle if you are heterosexual, bisexual, or homosexual

Are you in an abusive relationship? \_\_\_\_\_ Have you been sexually abused? \_\_\_\_\_

Tobacco use Current or Past \_\_\_\_\_ Quantity/day \_\_\_\_\_

Alcohol: Current or Past \_\_\_\_\_ Approximate amount/week \_\_\_\_\_

Illegal drugs: Current or Past \_\_\_\_\_ What type \_\_\_\_\_

Caffeine:  Yes  No Cups/day \_\_\_\_\_

HIV/AIDS Risks: \_\_\_\_\_  check if not sure

Do you have Advance Directive?  Yes  No

*Advance Directive is used to direct your health care in case your health condition worsens and you are no longer able to make a decision for your own healthcare needs.*

**HEALTH MAINTENANCE**

**IMMUNIZATIONS**

Type	Date
Tetanus Shot	
Pneumonia Shot	

Date of last physical exam? \_\_\_\_\_

Female Patients	Male Patients
Date of last menstrual period: _____	Date of last Prostate exam: _____
Are your periods regular? _____ Heavy? _____	Past abnormalities: _____
Length of cycle _____	Date of last PSA: _____
Total # of pregnancies: _____ Living children: _____	Past abnormalities: _____
#vaginal _____ # c/s _____	
Current method of birth control: _____	
Methods used in past: _____	
Date of last PAP: _____	
Past abnormalities: _____	
Date of last Mammogram: _____	
Past abnormalities: _____	

Screening (if applicable):

Date of last: Eye exam \_\_\_\_\_ Results \_\_\_\_\_

Colonoscopy/Flex sigmoidoscopy \_\_\_\_\_ Results \_\_\_\_\_

Cholesterol \_\_\_\_\_ Results \_\_\_\_\_

Bone density scan \_\_\_\_\_ Results: \_\_\_\_\_

## Tumesh for Optimal Health

# PATIENT PARTNERSHIP PLAN

### Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a “partnership” between you and your doctor. As our “partner in health,” we ask you to help us in the following ways:

#### **Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings**

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

#### **Keep Follow-up Appointments and Reschedule Missed Appointments**

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

#### **Call the Office When I Do Not Hear the Results of Labs and Other Tests**

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

#### **Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan**

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's or Authorized Representative's Signature





Your path to well-being and longevity

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_
STREET CITY STATE ZIP

Phone: \_\_\_\_\_

I voluntarily authorize and direct the Health Care Provider \_\_\_\_\_
NAME OF PROVIDER

Located at \_\_\_\_\_
STREET CITY STATE ZIP

PHONE / FAX

To provide a copy, summary or narrative of my medical records as indicated below by checkmarks. The release of medical data includes re-disclosure of medical information obtained from other Providers in accordance with my wishes to Tumesh for Optimal Health at the above address or fax number.

INFORMATION TO BE RELEASED

- Checkboxes for: Dates of Service, All records, Face sheet, Consultation Report, Lab/Pathology Report, Immunizations, Operative Report.

REASON FOR RELEASE OF RECORDS:

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: medical history, diagnosis, and/or treatment of tobacco, drug or alcohol abuse, mental illness or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), billing information, correspondence, and records from other health care providers that the above - named health care facility may hold.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_
Patient or Legally Authorized Representative

Print name of Patient or Legally Authorized Representative

Relationship to Patient