Your path to well-being and longevity

Tumesh for Optimal Health
REGISTRATION FORM

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

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	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.) Effective date:	Co-payment: $

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: _____ Date: _____

Reason for the Visit: _____

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

BIRTH HISTORY

Route of Delivery: ❑ Normal Vaginal ❑ C-Section ❑ Instrumental Vaginal

Birth Weight: _____ Complications: _____

Released from hospital: ❑ in 48 hours ❑ in 72 hours ❑ in 96 hours ❑ in 5 days or more

Reason for delayed discharge after delivery: _____

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

Lives with: ❑ Mother ❑ Father ❑ Both Parents ❑ Other

# of siblings: _____

Do you have pets? ❑ Yes ❑ No If yes, which kind? _____

HEALTH MAINTENANCE

IMMUNIZATIONS (may give IZZ card)

Type	Date

Date of last physical exam? _____

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 the 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

Tumesh for Optimal Health

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____ , understand I have the right to request a restriction as to how Protected
Patient/ Guardian
Health Information (PHI) is used / disclosed to carry out treatment, payment, or healthcare operations of Tumesh for Optimal Health. Tumesh for Optimal Health is not required to agree to any restrictions I may request. However if Tumesh for Optimal Health agrees to any such restrictions, the restriction is binding on Tumesh.

My PHI means health information including demographic information collected from me and created or received by my physician, another health care provider, a health plan or my employer. This PHI relates to my past, present or future physical or mental health or condition and identifies me or there's reasonable basis to believe the information may identify me.

I understand that Tumesh for Optimal Health can communicate with me regarding my PHI through fax, email, phone, regular mail and from protected patient portal on www.tumesh.com. I understand that Tumesh for Optimal Health cannot and does not guarantee the privacy or security of any messages being sent over the Internet.

I voluntarily authorize **Tumesh for Optimal Health** to communicate with me through:

- ❑ Fax: _____
- ❑ Email: _____
- ❑ Regular mail: _____
- ❑ Patient portal: _____
- ❑ Phone Number: _____ _____
  Home Phone Cell Phone

Tumesh for Optimal Health may leave voicemail or send a message regarding my:

- ❑ Appointments only
- ❑ Appointments and other health information

I hereby give **Tumesh for Optimal Health** permission to disclose my PHI to:

_____ _____
Name of Friend/ Relative Relationship to the Patient

_____
Address Phone Number

❑ I DO NOT Authorize **Tumesh for Optimal Health** to:

_____ _____ _____
Please list

Date:_____ _____
Print Name

`

_____
Patient/ Guardian Signature

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Tumesh for Optimal Health
4920 Barranca Parkway, Suite D
Irvine, CA 92604
Tel: 949-387-8422
Fax: 949-387-8423
www.tumesh.com

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

- ❑ 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