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:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Name:

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: ❑HMO ❑PPO ❑POS ❑EPO ❑Open Access

Please indicate primary insurance	❑ Caloptima	❑ Blue Cross	❑ Blue Shield	❑ Blue Cross Blue Shield	❑ Aetna

❑ Cigna	❑ HealthNet	❑ Medicare	❑ United HealthCare	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Subscriber's ID no.: (Not a Group no.)	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 :	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 the physician. I understand that I am financially responsible for any balance. I also authorize Quail Hill Family Health Center or insurance company to release any information required to process my claims.

_____I understand that all co-payments, co-insurance, and/or deductibles are due at the time of service – 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 understand that the Notice of Privacy Practices and Financial Policy of Tumesh for Optimal Health are available at the front desk and online at www.tumesh.com.

Patient/Guardian signature ***Date***

Tumesh for Optimal Health

MEDICAL HISTORY INFORMATION

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

Check the box that applies to you:

Are you: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

Members of your household, including yourself: _____

Are you in an abusive relationship? _____ Have you been sexually abused? _____

Check the box that applies to you:

Do you need assistance with: ❑ Housekeeping ❑ Cooking ❑ Shopping ❑ Driving ❑ Walking

❑ Showering ❑ Toileting

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.

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

HEALTH MAINTENANCE

IMMUNIZATIONS

Type	Date
Tetanus Shot	
Pneumonia Shot	

Date of last physical exam? _____

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 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

Please print:

I, _____, Date of Birth: _____

hereby give **Tumesh for Optimal Health** permission to disclose any and/or all medical

information on myself to _____
Name (Relative or Friend)

_____, _____
Relationship to the patient | Street number | City, State, Zip

_____
Home | Cell | Work

Tumesh for Optimal Health may contact me at _____
Phone number

- ❑ I Authorize **Tumesh for Optimal Health** to leave a message regarding:
  - ❑ Appointments only
    or
  - ❑ Appointments and other health information
    or
- ❑ I DO NOT Authorize **Tumesh for Optimal Health** to leave any message on answering device and/or with other person than me or the above named relative/friend/guardian.

Date: _____ _____
Patient Signature

_____ _____ _____
SS#

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Tumesh for Optimal Health
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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.

This authorization will remain in effect for one year from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date: _____

Signature: _____
Patient or Legally Authorized Representative

_____
Print name of Patient or Legally Authorized Representative

_____
Relationship to Patient