

TUMWATER *family practice* CLINIC

▪ 150 Dennis St SW ▪ Tumwater, WA 98501 ▪ Phone: 360-754-6367 ▪
▪ www.tfclinic.com ▪

Welcome to Tumwater Family Practice Clinic! We are honored that you have chosen us as your healthcare provider. Our goal is to provide high-quality, compassionate care in a timely and respectful manner.

NEW PATIENT APPOINTMENT DETAILS

Date: _____ Time: _____ Check-In Time: _____

Appointment Provider: _____

CLINIC HOURS

Our clinic is open seven (7) days a week. Office hours may vary by day and service type. For the most current hours and provider availability, please visit our website or patient portal.

APPOINTMENT PREPARATION

Please bring your current insurance card and a photo ID to help us verify your information. Notify our staff of any changes to your insurance, address, or contact information. Registration forms are updated annually.

PAYMENTS & BILLING

Copayments, deductibles, and outstanding balances are due at the time of service unless prior arrangements have been made with our Billing Department. Billing support is available Monday–Friday during normal business hours.

ARRIVAL & APPOINTMENT TIMING

Please arrive early for your appointment. If you arrive late, you may be asked to reschedule. While we strive to stay on schedule, emergencies may cause delays. You may choose to reschedule or wait to be seen.

MISSED APPOINTMENTS

Appointments not canceled at least 24 hours in advance may be subject to a missed appointment fee. Repeated missed appointments may result in dismissal from the practice. Please see our Financial Policy for details.

PATIENT PORTAL

We strongly encourage all patients to use the secure Patient Portal. The portal allows you to view test results, request refills, and send messages. Portal access can be set up at the front desk with a valid email address.

MEDICATION POLICIES

Tumwater Family Practice Clinic does not provide long-term opioid or chronic pain management services. Patients requiring specialized pain management may be referred to appropriate specialists.

Prescription refills are processed during weekday business hours. Please allow 48–72 hours for refill requests. New medications and antibiotics require an appointment and evaluation. After-hours refills are not provided.

REFERRALS

If your provider determines that specialty care is needed, a referral may be placed on your behalf. Some insurance plans require prior authorization before a referral can be completed. Processing times vary based on insurance requirements and specialist availability.

Please allow adequate time for referrals to be processed, which can often be 5-7 business days. Our referrals team will contact you if additional information is needed. It is your responsibility to notify our office if your insurance changes, as this may delay or impact referral processing.

PEDIATRIC & MINOR PATIENTS

A legal parent or guardian must be present for minor patient appointments unless legal documentation is on file. Immunization records are required for pediatric patients.

VACCINATION POLICY

Tumwater Family Practice Clinic follows CDC-recommended immunization guidelines to promote patient and community safety. Vaccination decisions are reviewed on a case-by-case basis, and we encourage open discussion with your provider.

FEEDBACK & QUESTIONS

We value your feedback. Please share questions or concerns during your visit, through the patient portal, or by calling 360-754-6367.

Thank you for choosing Tumwater Family Practice Clinic. We look forward to partnering with you in your healthcare.

Sincerely,

The Providers and Staff of Tumwater Family Practice Clinic

Tumwater Family Practice Clinic - Medical History Form

Patient Name: _____ Date of Birth: _____ PCP Provider: _____

Please complete this sheet by filling in the bubbles completely.

Social History:

Marital Status Married Single Separated Divorced Partner Widowed
Employed Yes No Occupation: _____
Do you smoke Yes No
Alcohol Use None Rarely 1-2 x/week 3-4 x/week 5+ x/week
Caffeine None 1-2 cups/day 3-4 cups/day 5+ cups/day
Do you chew tobacco Yes No
Regular Exercise Yes No How often: _____ What type: _____
Recreational Drug Use Yes No What type: _____

Family History: Have any of the family members listed been diagnosed with the following:

Father: Alive Deceased

Has a history of:

Cancer Diabetes Heart Disease High Blood Pressure

Mother: Alive Deceased

Has a history of:

Breast Cancer Other Cancer Diabetes Heart Disease High Blood Pressure

Siblings: # of brothers: _____ # of sisters: _____ # Alive: _____ # Deceased: _____

History of:

Breast Cancer Other Cancer Diabetes Heart Disease High Blood Pressure

Children: # of sons: _____ # of daughters: _____ # Alive: _____ # Deceased: _____

History of:

Breast Cancer Other Cancer Diabetes Heart Disease High Blood Pressure

Past Medical History - In the past, have you been diagnosed with any of the following:

| | | | |
|------------------------|---------------------------|------------------|---------------------------|
| Asthma | <input type="radio"/> Yes | Hypertension | <input type="radio"/> Yes |
| Diabetes | <input type="radio"/> Yes | CAD | <input type="radio"/> Yes |
| Arrhythmia | <input type="radio"/> Yes | Depression | <input type="radio"/> Yes |
| Neuropathy | <input type="radio"/> Yes | Hepatitis | <input type="radio"/> Yes |
| Seizures | <input type="radio"/> Yes | Sleep Apnea | <input type="radio"/> Yes |
| COPD | <input type="radio"/> Yes | Anxiety | <input type="radio"/> Yes |
| GERD | <input type="radio"/> Yes | Cancer | <input type="radio"/> Yes |
| Stroke | <input type="radio"/> Yes | Kidney Disease | <input type="radio"/> Yes |
| Allergies | <input type="radio"/> Yes | Fibromyalgia | <input type="radio"/> Yes |
| Inflammatory Arthritis | <input type="radio"/> Yes | High Cholesterol | <input type="radio"/> Yes |

**** See reverse side to list any other medical issues as well as any surgeries you have had****

**Tumwater Family Practice Clinic
Adult Patient Information Form**

Full Name: _____ Preferred Name: _____ DOB: _____

Sex Assigned at Birth: Female Male Gender Identity and Pronouns (optional): _____

Mailing Address: _____
(Street or PO box) (APT #) (City) (State) (Zip)

*We will send Billing Statements, Lab Results, and all other correspondence to this address.

Primary Phone#: _____ Cell Home Other: _____
(Appointment reminder calls will be sent to this number)

Secondary Phone#: _____ Cell Home Other: _____

Social Security #: _____ Employer: _____

Email Address: _____
By providing your email, you agree to be enabled for our Online Patient Portal

Preferred Communication Method: Phone Call Text Patient Portal

Marital Status: Single Married Divorced Widowed Separated

Who may we discuss your account/billing information with?

Spouse Partner: _____ Parent(s) Other: _____

Race: White Asian Black or African American American Indian/ Alaska Native Native Hawaiian or Other Pacific Islander More than one race Other Race: _____

Ethnicity: Non-Hispanic Hispanic Origin Unknown

Interpreter Services needed? Yes Language: _____

Emergency Contact:

Name: _____ Phone #: _____ Relation: _____

Preferred Pharmacies:

Name: _____ Location: _____

Name: _____ Location: _____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, & FINANCIAL RESPONSIBILITY

I authorize Tumwater Family Practice Clinic and my insurance company to release Protected Health Information (PHI) as necessary to process insurance claims. I authorize insurance benefits to be paid directly to the provider. I understand that I am financially responsible for charges not covered by my insurance. I consent to billing for qualifying telephone, video, or electronic visits initiated by me, including patient portal communications, when applicable. I understand that coverage depends on my insurance plan and that I am responsible for charges if coverage is denied, inactive, or assigned to another Primary Care Provider.

Signature _____

Printed Name: _____ Date: _____

