

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 - Pediatric Medical History Form

Parents - please help us by answering the following questions about your child's history.

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

Please complete this sheet by filling in the bubbles completely.

Birth History:

- | | | | |
|---------------------------|------------------------------|-------------------------|------------------------------|
| Adopted | <input type="checkbox"/> Yes | Birth by C-Section | <input type="checkbox"/> Yes |
| Problems during Pregnancy | <input type="checkbox"/> Yes | Problems after Delivery | <input type="checkbox"/> Yes |
| Premature | <input type="checkbox"/> Yes | Low birth weight | <input type="checkbox"/> Yes |

General History: Have the following occurred to your child:

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| Hospitalization(s)? | <input type="checkbox"/> Yes | Describe: _____ |
| Allergic Reaction(s)? | <input type="checkbox"/> Yes | To What: _____ |
| Are there developmental concerns? | <input type="checkbox"/> Yes | Describe: _____ |
| Are Immunizations Current? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Medical History: In the past has your child been diagnosed with any of the following:

- | | | | | | |
|-----------------------------|------------------------------|----------------------------|------------------------------|-----------------------|------------------------------|
| ADD | <input type="checkbox"/> Yes | Learning difficulty | <input type="checkbox"/> Yes | Esophageal reflux | <input type="checkbox"/> Yes |
| Allergies | <input type="checkbox"/> Yes | Poor weight gain | <input type="checkbox"/> Yes | Failure to thrive | <input type="checkbox"/> Yes |
| Autism | <input type="checkbox"/> Yes | Stuttering | <input type="checkbox"/> Yes | Heart Murmur | <input type="checkbox"/> Yes |
| Depression | <input type="checkbox"/> Yes | Undescended testis | <input type="checkbox"/> Yes | Hernia | <input type="checkbox"/> Yes |
| Ear Infections - Chronic | <input type="checkbox"/> Yes | Birth Defect(s) | <input type="checkbox"/> Yes | Lactose Intolerance | <input type="checkbox"/> Yes |
| Exposure to cigarette smoke | <input type="checkbox"/> Yes | ADHD-hyperactive/impulsive | <input type="checkbox"/> Yes | Milk protein allergy | <input type="checkbox"/> Yes |
| Seizures | <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> Yes | Speech/language delay | <input type="checkbox"/> Yes |
| Heart Problems | <input type="checkbox"/> Yes | Constipation | <input type="checkbox"/> Yes | Umbilical hernia | <input type="checkbox"/> Yes |
| Insomnia | <input type="checkbox"/> Yes | Developmental delay | <input type="checkbox"/> Yes | UTI | <input type="checkbox"/> Yes |

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

Mother:

- Allergies Asthma Cancer Diabetes Arthritis Seizures Stroke
 Mental Illness Alcoholism Heart Disease Hypertension Heart Attack Kidney Problems
 Thyroid Problems Bleeding Disorder

Father:

- Allergies Asthma Cancer Diabetes Arthritis Seizures Stroke
 Mental Illness Alcoholism Heart Disease Hypertension Heart Attack Kidney Problems
 Thyroid Problems Bleeding Disorder

Siblings # of brothers: _____ # of sisters: _____

- Allergies Asthma Cancer Diabetes Arthritis Seizures Stroke
 Mental Illness Alcoholism Heart Disease Hypertension Heart Attack Kidney Problems
 Thyroid Problems Bleeding Disorder

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

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

It is very important that we have accurate patient and family information. Please print clearly.

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: _____

Patient Direct Phone #: _____ (Patients 12yrs+)

Preferred Pharmacy: _____ **Location:** _____

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

Ethnicity: Non-Hispanic Hispanic Origin Unknown

Primary Contact Adult: (Same contact information as above)

Biological Parent Step-Parent Adoptive-Parent Foster-Parent Legal Guardian

Name: _____ Date of Birth: _____

SSN # (or) Driver's License #: _____

Secondary Contact Adult:

Biological Parent Step-Parent Adoptive-Parent Foster-Parent Legal Guardian

Name: _____ Date of Birth: _____

SSN # (or) Driver's License #: _____ Phone #: _____

Address: _____
(If different from the patient's address)

Emergency Contact: (Not listed above)

Name: _____ Phone: _____ Relation: _____

Primary Physical Custody Held By: _____

(If parental rights have been legally terminated, a court order must be on file.)

Biological Mother (if known): _____ Date of Birth: _____

Biological Father (if known): _____ Date of Birth: _____