TANGLEWOOD
PATIENT INFORMATION

Today's Date

_____

Welcome to Tanglewood Family Medical Center and thank you for choosing our clinic. In order to serve you properly, we need the following information. All information. All information is strictly confidential.

Patient's Primary Care Physician	Patient's Name (Last, First, MI)		
Preferred Name (Nickname)	Birthday (MM/DD/YY)	Sex ❑ Male ❑ Female	Marital Status ❑ Single ❑ Divorced ❑ Married ❑ Widowed
Address	City		
State Zip Code Home Phone	Cell Phone		
Name of Employer	Employer Address		
Work Phone (Include Extension)	Occupation	Social Security Number	
Employment Status ❑ Full Time ❑ Unemployed ❑ Part Time ❑ Home Maker ❑ Retired	Student Status ❑ Full Time ❑ Part Time	Responsible Party ❑ Self (If not self, provide name & relationship) Name	Relationship ❑ Spouse ❑ Parent ❑ Guardian ❑ Other
Emergency Contact Relationship to the Contact Person	Home Phone # Cell Phone # Work Phone #	Address ❑ Same as Patient	
Subscriber Name	❑ Spouse ❑ Parent ❑ Guardian ❑ Other	Subscriber's DOB Subsciber's SS#	
Do you have a DNR or a POA? ❑ Yes If yes, please provide a copy	Referred by ❑ Family ❑ Friend ❑ Web ❑ Insurance ❑ Previous Patient ❑ Hospital ❑ Facebook ❑ Self ❑ Other:		
Preferred Method of Communication. ❑ Letter ❑ Home Phone ❑ Cell Phone If Preferred Method is Phone, For your privacy, should messages be: ❑ Detailed or ❑ Short?			
Race ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African Am. ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Prefer not to Answer			
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic or Latino ❑ Prefer not to Answer			
Preferred Language: ❑ English ❑ Spanish ❑ Vietnamese ❑ Other (Specify) _____			
Preferred Pharmacy Address: _____ Patient Email Address _____			

Notice of Privacy Practices Summary/Acknowledgement

Maintaining privacy of your health information is very important to us. Attached to this letter you will find our *Notice of Privacy Practices.* The following is a brief summary of the content of the attached Notice. We encourage you to read the entire Notice and ask any questions you may have regarding its contents.

How We May Use and Disclose Health Information About You. This section describes the different ways we may use or disclose your health information without first obtaining a specific authorization from you. These types of uses and disclosures are specifically permitted by law because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the functioning of our health care system.

Your Rights Regarding Your Health Information. This section describes the following rights you have with respect to your health information and tells you how you may exercise these rights.

- Right to inspect and copy
- Right to request amendment
- Right to an accounting of disclosures
- Right to request restrictions on certain uses and disclosures
- Right to request alternative means of communication
- Right to receive a paper copy of our Notice of Privacy Practices

How to File Complaints Concerning Our Privacy Practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing a complaint.

We ask you acknowledge your receipt of this Notice by signing below. You should keep the copy of the attached Notice, however if you wish to receive another copy you may request a copy at any time. Also, the most current copy of our Notice will be posted in our office. If there are material changes to this Notice at a later date, you will be provided a copy of the revised Notice and asked to sign another acknowledgement.

I acknowledge that I received a copy of my provider's Notice of Privacy Practices with the effective date of April 14, 2003.

_____ _____

Signature of Patient/Patient Representative ***Date***

_____

Relationship to Patient

TANGLEWOOD FAMILY MEDICAL CENTER, PA.

606 MULBERRY RD

DERBY, KS 67037

RELEASE OF INFORMATION TO FAMILY AND FRIENDS

I authorize Tanglewood Family Medical Center to release my medical information to the following:

_____relationship_____

_____relationship_____

_____relationship_____

_____relationship_____

_____

Please print name

_____

Signature

_____

Date

TANGLEWOOD FAMILY MEDICAL CENTER, PA
606 N MULBERRY RD
DERBY, KS 67037

PAYMENT POLICY

We are committed to providing you with the best care possible. If you have medical insurance, we will assist you to ensure you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for all services that are your responsibility, such as co-payments, deductibles, and non-covered services, are due at the time services are rendered.
We accept cash, checks, VISA, and MasterCard.

Please be aware of these important facts:

1. Your insurance company is a contract between you, your employer and the insurance company.
2. We file insurance as a courtesy.
3. Not all services are a covered benefit in all contracts. We will attempt to alert you if we believe a service might not be covered, but please be aware we cannot be knowledgeable about all contracts. It is ultimately up to you to be informed about your insurance policy and its covered and non-covered services.
4. If you have any questions about your benefits, call your insurance company.
5. We have the option to report your account status to any credit-reporting agency such as a credit bureau. If we have to refer your account to a collection agency, you agree to pay all the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees that we incur plus all court costs. You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if you are past due, status is reported to a credit agency, the fact you received treatment at our office may become a matter of public record.
6. We have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.
7. There is a $25 fee for any checks returned by the bank.
8. Patients who do not cancel at least 24 hours before their scheduled appointment time, may be charged a **$40 fee**.
9. Patients who do not **reschedule** their appointment at least **12 hours** before their scheduled appointment time, may be charged a **$25 fee**.
10. Patients who do not show for an appointment may be charged a $40 fee. This fee must be paid before a new appointment is scheduled. Patients with two (2) missed appointments may be asked to transfer their records to a new doctor.
11. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
12. After insurance benefits have been received, a statement will be sent to the patient at which time balance is due in full.

Tanglewood Family Medical Center, PA
606 N Mulberry Rd, Derby, KS, 67037
(316)788-3787

Patient Name:
DOB:
Provider Name:

Informed Consent to Telemedicine Consultation

By signing this form, you consent to participate in telehealth/telemedicine (i.e. Virtual Visits, Telephone Visits) between you and your primary care provider or other healthcare individuals in order that they may provide you, or your dependents, patient care services and other clinical services utilizing live, two-way audio/video technology or via telephone only. Services utilizing such technology may be used for the purpose of diagnosis, therapy, follow-up and /or education, assessment, treatment, or other services.

1. **Expected Benefits:**
    - Improved access to health care by enabling a patient to remain at home (or at a remote site) while receiving care from a distance.
2. **Potential Risks:** Risks include but are not limited to:
    - In the event of interruption or disconnection of the audio/video connection, the continuity or completion of a particular telemedicine visit will depend upon whether the information transmitted is sufficient for the patient's condition. If the audio/video connection is inadequate for the purpose or is disconnected, Tanglewood Family Medical Center may require an in-person visit. Your health information will be transmitted electronically by audio and video. The security and confidentiality of information transmitted electronically may be compromised by the failure of security safeguards or illegal or improper tampering.
    - While Tanglewood Family Medical Center has taken reasonable and appropriate efforts to eliminate any confidentiality risks associated with your telemedicine appointment, Tanglewood Family Medical Center cannot control your environment or any company you may have during the telemedicine appointment.
3. **Nature of Telemedicine:**
    - During the telemedicine appointment, details of your medical history and current condition may be discussed by interactive audio/video technology.
    - Tanglewood Family Medical Center and its providers rely on information by you and it is your responsibility to provide information about your medical history, condition, and care that is complete and accurate to the best of your ability.
    - Tanglewood Family Medical Center and its providers' advice, recommendations, and decisions may be based on factors not within their control, such as incomplete or inaccurate data provided by you or distortions of audio/video during the telemedicine visit.
    - Tanglewood Family Medical Center has the right to determine if a telemedicine appointment is appropriate for your needs and may recommend an in-person appointment.
4. **Medical Records:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine visit. Your provider will document the medical information conveyed during the appointment into your medical record the same as if it were an in person visit. Please note, not all telecommunications are recorded and stored.
5. **Payment Agreement:** By signing below you understand that your insurance will be billed for any telemedicine services you receive from Tanglewood Family Medical Center; you may be billed for what your insurance does not cover, including any deductibles, coinsurance and copay; and you have been advised to check with your insurance carrier for coverage of telemedicine visits. If your insurer does not cover telemedicine visits then you will be responsible for the full fees for telemedicine services you received from Tanglewood Family Medical Center. If you have any questions about your billing, you should contact Tanglewood Family Medical Center’s billing office.
6. **Data and Devices:** Tanglewood Family Medical Center does not warrant that its telemedicine services will be compatible with any updates to, or prior versions of, your devices' operating systems. To the extent that your telemedicine appointment requires the use of wireless, cellular data, or internet access, you are responsible for securing the necessary data access service. E.g. your mobile phone provider may charge you data access fees in connection with your use of telemedicine services. You are solely responsible for all such charges payable to third parties.

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Patient Name:
DOB:
Provider Name:

7. **Patient Rights:** You may withhold or withdraw your consent to telemedicine at any time without affecting your right to future care or treatment.

By signing this form, I understand the following:

1. I have been advised of the potential risks, consequences, and benefits of telemedicine
2. I have had an opportunity to ask questions about the information presented on this form by contacting Tanglewood Family Medical Center prior to my visit.
3. All my questions have been answered and I understand the information provided above.

My signature below (or other written acknowledgement of my acceptance to the terms above) indicates my consent to participate in a telemedicine appointment in connection with the service (s) described above. The consent will be documented in my medical record with Tanglewood Family Medical Center.

Printed Name: _____

Signature: _____

Date: ____/____/_____

HEALTH HISTORY QUESTIONNAIRE

NAME (Last, First, M.I.):		**Male** ☐ **Female** ☐ **Other** ☐	**DOB**:	**DATE**:

PERSONAL HEALTH HISTORY

MEDICATIONS: List your prescriptions including OTC drugs such as vitamins and inhalers	☐ **No medications taken**

Name of Drug	Strength	Form	Frequency
(Example): Tylenol	500mg	tablet	1 tab every morning and evening

ALLERGIES: Include antibiotics, narcotics, anesthetics, Iodine, IV, dye, latex, insect bites, pollen, food

☐ **No known allergies**

Allergy	Reaction
(Example): Amoxicillin	Skin rash, Hives, etc

Names/Types of Specialists currently seen:	

Hospitalizations in the last year? Reason?	Date:	Location:

Surgeries/Procedures			**☐ No Surgeries/Procedures**	
☐ Appendectomy (Appendix)	Hysterectomy ☐ Partial ☐ Total	☐ Coronary Stent	☐ Vasectomy	☐ Knee Procedure
☐ Tonsillectomy	☐ Cesarean Section	☐ Coronary Bypass	☐ Prostate Procedure	☐ Hip Procedure
☐ Gall Bladder (Cholecystectomy)	☐ Tubal Ligation	☐ Heart Valve Surgery	☐ Colon Procedure	☐ Back Procedure
☐ Hernia Repair	☐ Breast Procedure/Surgery	☐ Cardiac Pacemaker	☐ Eye Procedure	☐ Sinus Procedure
Last Date Of:				
☐ Colonoscopy _____/_____/_____				
☐ Dexa Scan _____/_____/_____				
☐ Mammogram _____/_____/_____				
☐ Pap Smear _____/_____/_____				

MEDICAL HISTORY UPDATE: Check all that apply, write in others	☐ **No health problems**
Cardiovascular	☐ High Blood Pressure ☐ High Cholesterol ☐ Angina ☐ Heart Attack ☐ Irregular Rhythm ☐ Congestive Heart Failure ☐ Heart Valve Problem ☐ Rheumatic Heart Disease ☐ Stroke ☐ Varicose Veins ☐ Rheumatic Fever ☐ Valvular Heart Disease ☐ Mitral Valve Prolapse ☐ TIA
Endocrine	☐ Diabetes (year of onset:_____) ☐ Thyroid Disorder ☐ Adrenal Gland Disease
Pulmonary	☐ Asthma ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ Sleep Apnea ☐ Tuberculosis ☐ Valley Fever ☐ Chronic Bronchitis
Musculoskeletal	☐ Arthritis ☐ Chronic Back Pain ☐ Fractures/dislocations ☐ Osteoporosis ☐ Spasms ☐ Restless Leg Syndrome
Gastrointestinal/ Esophageal	☐ Diverticular Disease ☐ Esophageal Reflux (GERD) ☐ Hepatitis A/B/C ☐ Hemorrhoids ☐ IBS ☐ IBD ☐ Liver Problem ☐ Pancreas Problem ☐ Ulcer ☐ Bleeding
Renal	☐ Kidney Stones ☐ Renal Failure ☐ Recurrent Urinary Tract Infections
Hematological	☐ Anemia ☐ Blood Clots ☐ Blood Transfusion ☐ HIV Positive ☐ AIDS
Infectious	☐ Sexually Transmitted Infection ☐ MRSA ☐ Lyme
Neurological	☐ Migraine Headache ☐ Peripheral Neuropathy ☐ Seizures/Epilepsy ☐ Fainting Spells ☐ Parkinson's Disease ☐ Memory Disturbances ☐ Carpel Tunnel Syndrome ☐ Tremors
Ocular	☐ Diabetic Eye Disease ☐ Cataracts ☐ Glaucoma ☐ Color Blind ☐ Glasses/Contacts ☐ Lasik Surgery ☐ Diabetic Retinopathy ☐ Macular Degeneration
Psychiatric	☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Eating Disorder ☐ Obsessive Compulsive Disorder ☐ Adjustment Reactions ☐ Other:
Cancer	List Type(s):

SOCIAL HISTORY AND HABITS

Tobacco	**Smoking Status:** ☐ Never Smoker ☐ Former Smoker ☐ Secondhand smoke exposure: high ☐ Secondhand smoke exposure: low ☐ Current every day Smoker ☐ Current some day Smoker ☐ Heavy tobacco Smoker ☐ Unknown tobacco status _____Number of years smoking	**Tobacco Type** ☐ Cigarettes ☐ Cigars ☐ Oral ☐ Pipe ☐ Other:	**Describe your daily tobacco use** _____# packs _____# cigarettes _____# chew	**Previous Quit Attempts** ☐ None ☐ Counseling ☐ Hypnosis ☐ Medications ☐ Nicotine replacement ☐ Other:
Caffeine	None	Coffee	Tea	Other	Amount per day?
Alcohol	Do you drink alcohol? ☐ Yes ☐ No		If yes, what type/amount per week?		
Drugs	Do you use recreational drugs? ☐ Yes ☐ No		Type:		Amount:
Sexuality	☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender ☐ Questioning				
Marital Status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Employment/School	Occupation?		Place of employment/school?		

FOR WOMEN
☐ Vaginal Discharge ☐ Vaginal Dryness or Irritation ☐ Change in Libido (sexual interest)
☐ Early loss of ovarian function ☐ Hyperthyroidism ☐ Chronic diarrhea or intestinal malabsorption syndrome
☐ # of Pregnancies (total)_____ ☐ # of Miscarriages_____ ☐ # of Abortions _____
☐ Have had an eating disorder such as anorexia or bulimia ☐ Low calcium intake ☐ Little or no exposure to sun
☐ High caffeine intake (2-3 cups/day)
☐ History of inflammatory bowel disease ☐ Obesity ☐ History of colorectal cancer or polyps
☐ Heavy alcohol use ☐ Inactive lifestyle

FOR MEN
□ Changes in Urinary Stream □ Changes in Libido (sexual interest)
Any issues concerning… (check all that apply):
□ Premature Ejaculation
□ Erectile Dysfunction
□ Sexual Activity, or Fulfillment with Regard to Self or Partner
If yes, please explain: _____

IMMUNIZATIONS

Please indicate with an X whether you've had the following immunizations, and the date of your most recent vaccination.

Name of Immunization	Yes?	No?	Date
Influenza			
Pneumococcal PPSV23 (Pneumovax)			
Pneumococcal PCV13 (Prevnar)			
Hepatitis A series			
Hepatitis B series			
Tetanus booster (dT)			
Tetanus & pertussis booster (Tdap)			
Measles, Mumps, Rubella (MMR)			
Shingles (Zostavax)			
Diphtheria, Tetanus, & Acellular Pertussis			
Rotavirus (RV)			
Inactivated poliovirus			
Human Papillomavirus (HPV) *males and females*			
Meningococcal B			
Other:			
Other:			
Other:			
Other:			

ASSESSMENT OF RISK FACTORS: VISION, HEARING AND ORAL HEALTH: Please check Yes or No and elaborate as needed.

Date of most recent Eye Exam:_____Date of most recent Dental Exam: _____

Yes No

- ☐ ☐ If you are 65 yrs. or older, do you see an eye doctor for regular annual eye exams?
  (If younger than 65, please leave blank)
- ☐ ☐ Do you have a history of glaucoma?
- ☐ ☐ Do you have a family history of glaucoma?
- ☐ ☐ Do you have a history of diabetes mellitus?
- ☐ ☐ Do you wear glasses or contact lenses?
- ☐ ☐ Do you see a dentist at least annually?
- ☐ ☐ Do you brush your teeth daily with toothpaste?
- ☐ ☐ Do you use dental floss?

ASSESSMENT OF RISK FACTORS: WOMEN'S HEALTH: Please check Yes or No and elaborate as needed. If male, please leave blank.

Yes No

- ☐ ☐ Have you had a Pap smear within the past 3 years?
- ☐ ☐ Are you currently or have you ever been sexually active?
  If yes, onset age of sexual activity? _____
  If yes, number of lifetime partners? _____
- ☐ ☐ Have you ever had an abnormal Pap smear?
  If yes, date of abnormal Pap smear___/___/___
  What treatment(s) did you receive, if any? _____
- ☐ ☐ If you are 40 yrs. or older, have you had a mammogram within the past 1-2 yrs? (If younger, please leave blank)

ALCOHOL CONSUMPTION: Please check Yes or No and elaborate as needed.

Yes No

- ☐ ☐ In the past month, did you get drunk or very high on beer, wine or other alcohol?
- ☐ ☐ In the past month, did any of your close friends get drunk or very high on beer, wine or other alcohol?
- ☐ ☐ Have you ever been criticized or gotten into trouble because of drinking?
- ☐ ☐ In the past year, have you used alcohol and then driven a car/truck/van or motorcycle?
- ☐ ☐ In the past year, have you been in a vehicle when the driver has been drinking alcohol or using drugs?
- ☐ ☐ Does anyone in your family drink or take drugs so much that it worries you?

FAMILY HEALTH HISTORY

To the best of your knowledge, Do you have a parent, sibling, child with the following? Please select the family member(s). ☐ **Unknown** ☐ **Adopted**

	Father	Mother	Other- how related?		Father	Mother	Other- how related?
Cancer: Ovarian/Uterine				Osteoporosis			
Cancer: Breast				High Blood Pressure			
Cancer: Prostate				Elevated Cholesterol/Lipids			
Cancer: Colon				Multiple Sclerosis			
Cancer: Other type?				Ulcers/Stomach Disorders			
Diabetes				Bowel Polyps			
Heart Disease				Anxiety			
Hypertension				Mental Illness			
Brain Aneurysms (cerebral)				Depression			
Abdominal Aneurysms (Aortic)				Manic Depression			
Allergies/Asthma				Glaucoma			
Hearing Loss				Alzheimer's/Memory Loss			
Thyroid Disease				Obesity			
Stroke				Parkinson's			
Migraine Headaches				Other:			