TURNER MEDICAL ARTS

Dear Patient,

Welcome to our practice! We thank you for choosing Turner Medical Arts for your medical care.

Our medical practice is patient centric, delivering unparalleled medical care. As a new patient, there are some things you should know before your appointment.

We are located at **737 Garden Street** - on the corner of Garden and De La Guerra Streets, Santa Barbara.

Our parking structure is located on the south / west corner of Garden Street but there is usually ample street parking as well.

Dr. Duncan Turner is not contracted with insurance and is considered an "out of network" provider. Payment to our office is due at the time services are rendered. For questions regarding insurance please visit our website: **http://www.turnermedicalarts.com/patient-resources/gynecology-insurance.html**

We know waiting isn't fun – we take your time seriously, and we hope you will do the same for us. Our Cancellation Policy requires 24 hour notice. Cancellations with less than 24 hours notice will be subject to a $100.00 charge. We appreciate your understanding.

Credit Card Information:

Card Number: _____-_____-_____-_____ Exp Date: _____ / _____ CVV: _____ _____ _____

Please complete the attached new patient paperwork completely and bring to your appointment. If you do not have access to a printer, please arrive to your appointment 15 minutes early to complete these forms in the office.

We look forward to seeing you soon,

Signature: _____ Date: _____

737 Garden Street
Santa Barbara, California 93101
Phone: 805-962-1957 Fax: 805-966-3428
Get the right advice. Your health matters. We take it seriously.
www.turnermedicalarts.com

Medical Questionnaire

Name: _____ Date: _____

Referred By: _____

Primary Care Physician: _____ Smoker: ☐ Yes ☐ No

Eating Habits: _____ Exercise – Type / Frequency: _____

Allergies: _____

Reason for Visit: _____

_____

Medical History: _____

_____

_____

Pregnancies: _____ Deliveries: _____

Surgeries (including dates): _____

_____

Family History: _____

_____

_____

Any Further important information: _____

_____

_____

I HEREBY REQUEST THAT A COPY OF MY MEDICAL RECORDS BE FAXED FROM:

DR. DUNCAN TURNER, MD
737 Garden Street
Santa Barbara, California 93101

TO:

_____

NAME OF MEDICAL PHYSICIAN / FACILITY:

_____

ADDRESS OF PHYSICIAN / FACILITY:

_____

CITY, STATE, ZIP CODE:

_____

PHONE NUMBER: FAX NUMBER:

_(_____)_____(_____)_____

PATIENT NAME: _____

DATE OF BIRTH: _____

COMMENTS:

_____

_____

_____

TURNER MEDICAL ARTS

To:

_____

Name of Medical Facility/ Physician:

_____

Address of Facility / Physician:

_____

City, State, Zip:

_____

Tele: _____ Fax: _____

Records being requested:

☐ _____

I hereby request that a copy of my medical records be sent to:

Dr. Duncan Turner, MD
737 Garden Street
Santa Barbara, California, 93101

infor@turnermedicalarts.com

Tele: 805-962-1957 Fax: 805-966-3428

Patient Name: _____

Date of Birth: _____

Address: _____
_____

Telephone Number: _____

Patient Signature: _____

Date: _____

Confidentiality Consent Form

I, _____ hereby authorize **DUNCAN TURNER , MD** and Staff to release any information to the following sources:

Insurance Company's:

_____

Physician:

_____

_____

_____

Other Personals Listed below:

_____

_____

_____

Signature: _____ Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Email Address: _____

Permission to use email for communication? ☐ Yes ☐ No

Preferred Phone Number: _____

Permission to leave detailed message? ☐ Yes ☐ No

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married

Partner Name: _____ Occupation: _____

Notify in case of Emergency? _____ Relationship: _____

Phone Number: _____

Preferred Pharmacy & Address: _____

How did you hear about us?

☐ Google ☐ Turner Medical Arts website ☐ Yelp ☐ Radio ☐ RealSelf ☐ Facebook ☐ Staff

☐ Twitter ☐ Independent ☐ Pinterest ☐ Instagram ☐ Santa Barbara Magazine ☐ Event

☐ Walk in ☐ Physician: _____ ☐ Other: _____
(Name)

☐ Friend: _____ *Friend Rewarded!!!
(Name)

TURNER MEDICAL ARTS

Cancer Risk Assessment

_____ _____/_____/_____ _____/_____/_____

Patient Name Date of Birth Date Completed

This is a screening tool for the common features of hereditary cancer. Our service will allow us to give you the most technologically advanced screening possible to increase the chances of cancer detection and early intervention to optimize your health.

Circle Y for those that apply to <u>YOU and/or YOUR FAMILY</u> (consider all relatives on both mother's and father's side). YOU AND THE FOLLOWING CLOSE BLOOD RELATIVES SHOULD BE CONSIDERED. ***Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins, Great Grandparents, Great Aunt/Uncle***

		CANCER	SELF/ SIBLING AGE AT DIGNOSIS	RELATIONSHIP TO FAMILY MEMBER w/ CANCER: MOTHER or Relatives on MOTHERS's side (Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins)	RELATIONSHIP TO FAMILY MEMBER w/ CANCER: FATHER or Relatives on FATHER's side (Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins)
		EXAMPLE:	Me 35 Sister 40	Aunt 35	Grandmother 75
Y	***N***	Colon Cancer before Age 50?			
Y	***N***	Endometrial Cancer before Age 50?			
Y	***N***	Two or more of the following cancers in the same person or on the same side of the family at any age? *(Lynch syndrome cancers: uterine, colon, ovarian, stomach, ureter, small bowel, pancreas, brain)*			
Y	***N***	Ten or more lifetime colon polyps?			
Y	***N***	Ashkenazi Jewish ancestry ***with*** breast or ovarian cancer in a ***family member*** at any age?			
Y	***N***	Ovarian cancer at any age?			
Y	***N***	Male breast cancer at any age?			
Y	***N***	Breast cancer at 50 years of age or younger?			
Y	***N***	Two breast cancer diagnoses in a SINGLE person, with one diagnosed at 50 years of age or younger?			
Y	***N***	Two breast cancers on the same side of the family with one diagnosed at 50 years of age or younger?			
Y	***N***	Three or more breast cancers on the same side of your family diagnosed at any age?			
Y	***N***	Combination of three or more of the following cancers on the same side of the family diagnosed at any age? Pancreatic, prostate, breast or ovarian cancers.			

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Patient offered testing ☐ Accepted ☐ Declined

Patient MRN# _____

Reason for Decline: