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New Patient Form

Pregnancy/Obstetrics

Name:____ E-mail:____

Cell Phone:____ Work Phone: _____________________ Home Phone:_____________

Street Address:____City:______________________State:_____Zip: _________

Date of Birth:________________________ Age:_____________

Pharmacy Name:________________________________Pharmacy Zip: _____________

Emergency Contact Name: ______________________ Emergency Contact Number: _____________________

INSURANCE INFORMATION

PRIMARY INSURANCE	
Insurance Company Name:	Policy Holder's Name:
ID or Policy Number:	Relationship to Patient:
Group Code:	Policy Holder's Date of Birth:
Employer:	

AUTHORIZATION

I authorize payment of medical and surgical benefits to Dr. Tangchitnob's office or their designee for services rendered.
❐ Yes ❐ No

If services rendered are not covered by my insurance, I understand that I will be responsible for the balance due.
❐ Yes ❐ No

I hereby authorize the office of Dr. Tangchitnob to release information pertaining to my care to other medical providers as needed.
❐ Yes ❐ No

I hereby authorize Dr. Tangchitnob and his staff to contact me via telephone regarding any medical information.
❐ Yes ❐ No

I hereby authorize Dr. Tangchitnob and his staff to relay any messages and information pertinent to my health to the following as needed:

❐ Family Members (spouse and children) ❐ My Health Insurance

Patient's Name Printed: ____

Patient's Signature: ____ Date: ________________

ALLERGIES Including medications, food, cosmetics, latex, etc.:

____
____

PAST MEDICAL HISTORY

MEDICAL HISTORY

____
____
____

SURGICAL HISTORY

Procedure: ______________________________ Date: ________ Procedure: _______________________________ Date: ________

Procedure: ______________________________ Date: ________ Procedure: _______________________________ Date: ________

MEDICATIONS.:

____

____

FAMILY HISTORY

Age(s) Health Status

Father: ___________________ ____

Mother: __________________ ____

Sibling: ___________________ ____

Sibling: ___________________ ____

Child: ____________________ ____

HABIT

Alcohol ❒ Yes ❒ No Smoking ❒ Yes ❒ No Recreational Drugs ❒ Yes ❒ No

If you answered yes, specify how much / how frequent (e.g. alcohol intake per week, cigarette packs per day)

____

PREGNANCY HISTORY *for women only

Number of Pregnancies? ______________________________ Number of deliveries? _______(vaginal) _____________(c-section)

Number of abortions? ______________________________ Number of miscarriages? ____________________________________

During previous pregnancy: High Blood Pressure? Diabetes? ___________________ Willing to Take Blood Transfusion? ___________

SYMPTOMS

Any current weight loss or poor appetite ❒ Yes ❒ No
Tiredness, fainting spells ❒ Yes ❒ No
Abnormal vision ❒ Yes ❒ No
Chest pain, heart palpitations ❒ Yes ❒ No
Headache ❒ Yes ❒ No
Abdominal pain, bloating ❒ Yes ❒ No
Breathing difficulty ❒ Yes ❒ No
Abnormal or leaking urination ❒ Yes ❒ No
Backache ❒ Yes ❒ No
Depression ❒ Yes ❒ No
Abnormal bowel movements ❒ Yes ❒ No
Sleeping problems ❒ Yes ❒ No
Hot flashes ❒ Yes ❒ No
Loss of sensation in hands/feet ❒ Yes ❒ No
Weakness ❒ Yes ❒ No
Abnormal vaginal discharge ❒ Yes ❒ No
Abnormal or painful menstruation ❒ Yes ❒ No

MENSTRUATION

Age at onset: _____________ Are your cycles regular? ❒ Yes ❒ No Cycle: __________ days Lasts: _________days

❒ Heavy ❒ Medium ❒ Light First day of last period: _____________ ❒ Normal ❒ Abnormal

INCONTINENCE

❒ Yes ❒ No I loose urinate when I sneeze, cough or jog

HEALTH CARE MAINTAINENCE.:

Last Pap Smear Date: _____________Last Mammogram Date: __________