Edward Tangchitnob, *MD, FACOG, FACS*
Dumrong Tangchitnob, *MD, FACOG*

New Patient Form
General

Name:_____ E-mail:_____

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

_____

_____

_____

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SURGICAL HISTORY

Procedure: _____ Date: _____ Procedure: _____ Date: _____

Procedure: _____ Date: _____ Procedure: _____ Date: _____

MEDICATIONS:

_____

_____

FAMILY HISTORY

	Age(s)	Health Status
Father:	_____	_____
Mother:	_____	_____
Sibling:	_____	_____
Sibling:	_____	_____
Child:	_____	_____
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

How many C-Sections? _____ How many pre-mature deliveries? _____

How many abortions? _____ How many miscarriages? _____

SYMPTOMS *those noted with an asterisk are for women only

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 *for women only

Age at onset: _____ Are your cycles regular? ❒ Yes ❒ No Cycle: _____ days Lasts: _____days

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

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INCONTINENCE

❒ Yes ❒ No I have strong, sudden urges to urinate

❒ Yes ❒ No I go to the bathroom more than I used to (> 8 times a day)

❒ Yes ❒ No I worry that sometimes I won't make it to the bathroom in time

❒ Yes ❒ No I go to the bathroom so often at night that it interferes with my sleep (2 or more times)

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

❒ Yes ❒ No I feel that I am not able to empty my bladder

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Our Office is Expanding!

We are happy to announce that we are now ALSO offe
you feel and look your best!

If you would like a complimentary consultation during your appointment, please fill out this sheet and select areas that interest you.

- ☐ HORMONE OPTIMIZATION – Bio-identical hormones that will boost your energy as well as help with sleep, mood and/or menopausal symptoms with natural pellet therapy
- ☐ NUTRACEUTICALS – Supplements that will boost a healthy lifestyle
- ☐ SKIN CARE – Creams and serums that will help with fine lines, skin texture and skin tone
- ☐ BODY SCULPTING & CONTOURING – Hot or cold treatments to permanently get rid of stubborn pinchable pockets of fat with CoolSculpting® or laser liposuction
- ☐ SEXUAL WELLNESS – Treatments that will increase sexual sensation and function for both men and women
- ☐ FACIAL WRINKLES – Botox, fillers or Vampire Facials to help smooth and minimize signs of aging
- ☐ WEIGHT LOSS – HCG 21 Day Diet and treatment plan to lose up to 10-15 pounds