TANGCHITNOB MD

MINIMALLY INVASIVE ROBOTIC SURGICAL GROUP FOR OBSTETRICS & GYNECOLOGY

NEW PATIENT FORM

Today's Date/Fecha: _____ / _____ / _____ DOB/Fecha de Nacimiento: _____ / _____ / _____

Name/Nombre: _____ Age/Edad: _____

Address: _____
Direccion Street/Calle City/Cuidad State Zip/Código

Home Phone/Teléfono: (_____) _____ - _____ Mobile: (_____) _____ - _____

Race/Raza: _____ Email: _____

Pharmacy Name: _____ Pharmacy Zip: _____

INSURANCE INFORMATION:

Insurance Primary/Aseguranza Primaria: _____

Insurance Secondary/Aseguranza Secundaria: _____

Social Security No./Seguro Social: _____ - _____ - _____ Insure SS#: _____ - _____ - _____

Employer/Empleador: _____ Phone/Teléfono: (_____) _____ - _____

Business Address/Direccion de Tabajo: _____

Occupation/Ocupaccion: _____

Name of Spouse/Nombre de Esposo: _____

Name of Friend in Area: _____ Phone/Teléfono: (_____) _____ - _____

Name of Relative: _____ Phone/Teléfono: (_____) _____ - _____

Name of Referring Person/Physician/PCP: _____

AUTHORIZATION:

1. I hereby authorize payment directly to above physician of the surgical, medical benefits if any otherwise payable to me for his services as described on attached claim.
   ☐ YES ☐ NO
2. I realize that this may not represent a full payment for services rendered and I will be responsible for balance due that is not covered by my insurance.
   ☐ YES ☐ NO
3. I hereby authorize above named physician to release any information acquired the course of my examination or treatment.
   ☐ YES ☐ NO
4. I hereby authorize the above named physician and his staff to contact me via telephone regarding medical information.
   ☐ YES ☐ NO

Patient's Name: _____ Date: _____

Patient's Signature: _____

1135 S Sunset Ave, Ste 102, West Covina, CA 91790 • Tel: (626) 338-5377 • Fax: (626) 851-8822

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I hereby have received a copy of Dumrong Tangchitnob MD and It's Affiliated Physicians' Notice of Privacy Practice.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Age: _____ ☐ Married ☐ Single

FAMILY HISTORY:

	AGE(S)	HEALTH STATUS
Father:		
Mother:		
Siblings:		
Siblings:		
Spouse:		
Children:		

PAST MEDICAL HISTORY:

MEDICAL HISTORY:

1. _____ 2. _____

SURGICAL HISTORY:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

PREGNANCY HISTORY:

How many stillborns: _____ How many premature children: _____

How many abortions: _____ How many miscarriages: _____

Did you have a C-Section? ☐ YES ☐ NO

SYMPTOMS (Please mark if there are any symptoms listed below):

1.	Any current weight loss or poor appetite	☐ YES	☐ NO
2.	Tiredness, weakness, fainting spell	☐ YES	☐ NO
3.	Abnormal visions, headache	☐ YES	☐ NO
4.	Chest pain, heart palpitation	☐ YES	☐ NO
5.	Breathing Difficulty	☐ YES	☐ NO
6.	Abdominal Pain, Bloating Symptoms	☐ YES	☐ NO

SYMPTOMS Cont. (Please mark if there are any symptoms listed below):

7.	Backache	☐ YES	☐ NO
8.	Abnormal Urination, Leaking Urination	☐ YES	☐ NO
9.	Abnormal Bowel Movement (diarrhea, constipation, bloody stool)	☐ YES	☐ NO
10.	Hotflashes, Depression, Sleeping Problem	☐ YES	☐ NO
11.	Weakness, Loss of Sensation of Extremities	☐ YES	☐ NO
12.	Abnormal Menstruation	☐ YES	☐ NO
13.	Painful Menstruation	☐ YES	☐ NO
14.	Abnormal Vaginal Discharge	☐ YES	☐ NO

ALLERGY:

Food: _____

Drug: _____

MEDICATION:

_____

_____

MENSTRUATION:

Age at onset: _____ Regular: ☐ YES ☐ NO Cycles: _____ days Lasts: _____days

☐ Heavy ☐ Medium ☐ Light Last day of period: _____ ☐ Normal ☐ Abnormal

HABIT: ☐ Alcohol ☐ Smoking ☐ Street Drugs

Patient's Signature: _____ Date: _____

I, _____ give consent to Dr. Tangchitnob and office staff to relay any messages and information pertinent to my health to the following:

☐ Family Members (spouse and children) ☐ Friends and Relatives ☐ Employer(s) & Co-Worker(s) ☐ My Answering Machine ☐ My Health Insurance

Name: _____ Signature: _____ Date: _____

INCONTINENCE QUESTIONS

1.	I have strong, sudden urges to urinate.	☐ YES	☐ NO
2.	I go to the bathroom more than I used to (>8 times/day).	☐ YES	☐ NO
3.	I worry that sometimes I won't make it to the bathroom in time.	☐ YES	☐ NO
4.	I go to the bathroom so often at night that it interferes with my sleep (2 or more times).	☐ YES	☐ NO
5.	I loose urinate when I sneeze, cough or jog.	☐ YES	☐ NO
6.	I feel that I am not able to empty my bladder.	☐ YES	☐ NO
7.	I am not aware when I lose my urine.	☐ YES	☐ NO

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ADVANCED DIRECTIVE ACKNOWLEDGMENT

Dumrong Tangchitnob, MD., Inc. and Its Affiliated Physicians respects your right to self-determination in health care decision making. This facility will comply with all state and federal laws regarding the implementation of Advance Directives.

All of us at Dumrong Tangchitnob, MD., Inc. and Its Affiliated Physicians want our patients to understand their rights to make medical decisions. Dumrong Tangchitnob, MD., Inc. and Its Affiliated Physicians complies with California laws and court decisions on Advance Directives. We do not condition the provision of care or otherwise discriminate against anyone based on whether or not you have executed an Advanced Directive. We have formal policies to ensure that your wishes about treatment will be followed.

It is your responsibility to provide a copy of your Advance Directive to the hospital so that it can be kept with your records.

Please answer the following:

1.	I have executed an Advance.	☐ YES	☐ NO
2.	I have been given written materials about my rights.	☐ YES	☐ NO
3.	I would like to receive additional information regarding Advanced Directives.	☐ YES	☐ NO
4.	I have received the additional information regarding Advance Directives.	☐ YES	☐ NO

Patient's Signature: _____ Date: _____

Patient's Name: _____ DOB: _____ / _____ / _____

Comments: _____

_____

_____

_____

_____

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ACEPTACIÓN SOBRE DECISIONES AVANZADAS

Dumrong Tangchitnob, MD., Inc. and Its Affiliated Physicians respeta su derecho de autodeterminación y decisión acerca de su cuidado médico. Este centro médico cumple con su las leyes federales y estatales que exigen la implementación de decisions avanzadas.

Todos en este centro médico queremos que nuestros pacientes comprendan el derecho que tienen a tomar decisiones sobre su cuidado médico. Dumrong Tangchitnob, MD., Inc. and Its Affiliated Physicians cumple con la ley de California y la decisión de la corte sobre decisiones avanzadas. Nosotros proveemos un cuidado incondicional sin discriminar a nadie respetando cualquiera que sea su decisión. Nosotros tenemos reglas formales para asegurar que su decisión será respetada.

Es la responsabilidad del paciente de proveer a este centro médico con una copia de decisiones avanzadas para poderla mantener en su archivo médico.

Por favor responda la siguiente:

1.	Yo he ejecutado decisiones avanzadas.	☐ SI	☐ NO
2.	Yo he recibido informacion escrita sobre mis derechos.	☐ SI	☐ NO
3.	Me gustaría recibir información adicional sobre las decisiones avanzadas.	☐ SI	☐ NO
4.	Yo he recibido información adicional sobre las decisiones avanzadas.	☐ SI	☐ NO

Firma del Paciente: _____ Fecha: _____

Nombre del Paciente: _____ DOB: _____ / _____ / _____

Comentarios: _____

_____

_____

_____

_____