DR. CHEN OB/GYN, P.A.

YAT-MIN CHEN, M.D.; F.A.C.O.G.

Board Certified in American Board of Obstetrics and Gynecology

5350 W. Hillsboro Boulevard, Suite 102,

Coconut Creek, FL 33073

Tel. (954) 725-7660 Fax: (954) 725-7605

PATIENT NAME: ____________________

DOB: ________/________/________

Pharmacy: ____________________

Phone #: ____________________

Major Problem Hx:

DATE	Problem	Management & Medication	Date Resolved

PATIENT INFORMATION

Name_____ **Telephone**_____
Last First Middle Int.

Address_____
Street city zip

Employment_____
Name address **telephone** position

Age_____ **Date of Birth** _____/_____/_____ # of Years Married _____ Marital Status M S DV Sep W (circle one)

Social Security No._____ **Driver's License No.**_____

Husband Name_____ **Husband DOB:**_____/_____/_____ & SSN_____
Last First Middle

Husband/Parent Employment_____
Name address telephone position

Nearest of Kin (other than husband)_____
Name address telephone relation

Referred by _____

Insurance Information_____
Plan Name **ID#** **Group#**

Medicinal Allergies _____ **Present Medication**_____

History of Surgery _____

I understand that I am financially responsible for all charges whether or not paid by said insurance regardless of insurance coverage, and/or non-insurance covered charges, deductibles and co-insurance amounts incurred in this office, and that payments are due at the time services are rendered. I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and I agree to pay said collection agency's fees for collection, which ma be based on a percentage at maximum of 30% of the debt, court costs, and/or reasonable attorney fees that may incurred in the collection of any outstanding balance.
The office reserves the right to charge interest on the unpaid balances at the rate of 1.5% per month.

I authorize Dr. Yat-Min Chen to release any information acquired in the course of examination or treatment. I authorize any physician, hospital, or medical facility to provide all information on my medical history. I also authorize treatment by Dr. Yat-Min Chen and other physician, hospital or medical facility, where parent or responsible party cannot be contacted.

I authorize payment of medical benefits from my insurance company to go directly to Dr. Yat-Min Chen.
I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Date _____/_____/_____ Patient or Responsible Party_____

Dr.Chen OB/GYNP.A._____

Medical History Form

Name: _____ Date of Birth: _____ Today's date: _____

Chief Complaint: _____

Obstetric & Gynecology History: Please list method as C/Section, Vaginal (SVD), Miscarriage (Sp. Ab), Termination of Pregnancy (TOP), D&C; also Gestational Age (GA) as weeks or months.

	Month/ Year	GA wks/ months	Method	Complication &/ or Reason	Weight	Male or Female
1st Pregnancy						
2nd Pregnancy						
3rt Pregnancy						
4th Pregnancy						
5th Pregnancy						
6th Pregnancy						
7th Pregnancy						
8th Pregnancy						

Menstruation History:
Age of 1st period (Menarche): ____ y/o; **Interval between 1st day of each period:** _____ days;
Duration of each period last: _____ days; **Regular** cycle or not: ☐yes, ☐no.

Menopause: at age of _____ y/o; ☐Natural, ☐Total Abdominal Hysterectomy, ☐Total Vaginal Hysterectomy ☐Laparoscopic Total Hysterectomy, ☐Laparoscopic Supracervical Hysterectomy, ☐Bilateral Salpingoophorectomy

Contraception: ☐None, ☐Birth Control Pill, ☐Bilateral Tubal Ligation, ☐Condom, ☐Depoprovera Shot, ☐Implanon, ☐IUD, ☐Natural ☐Nuva Ring, ☐Patch, ☐Vasectomy, ☐Others: _____

History of sexual Transmitted Disease: ☐None, ☐Cervical Dysplasia, ☐Chlamydia, ☐Genital Warts, ☐Gonorrhea, ☐Hepatitis B, ☐Hepatitis C, ☐Herpes Simplex, ☐HIV ☐HPV, ☐Syphilis, ☐VAIN/ Vaginal Dysplasia, ☐VIN/ Vulva Dysplasia, ☐Others: _____

History of Gynecology Surgery: ☐None ☐C/S ☐Colpopexy/ Anterior-Posterior Repair ☐Cryotherapy ☐D&C ☐Ectopic Pregnancy ☐Hysteroscopy ☐Laparoscopy ☐LEEP/ Cone Biopsy ☐Laparoscopic Total Hysterectomy ☐Laparoscopic Supracevical Hysterectomy ☐Ovarian Cystectomy ☐Oophorectomy ☐Total Abdominal Hysterectomy ☐Total Vaginal Hysterectomy ☐Tubal Reversal/ Tuboplasty ☐Urethropexy ☐Total Vaginal Hysterectomy ☐Vulvectomy ☐Others: _____

Past Medical History:

☐None ☐Abnormal Mammogram ☐Abnormal Pap Smear ☐Anemia, ☐Arthritis/Joint Disease ☐Asthma ☐Breast Disease ☐Cancer ☐COPD ☐Depression ☐DM ☐DVT ☐GI Disease ☐Hay Fever ☐Hearing Loss ☐Hair Loss ☐Heart Disease ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐HIV ☐Hypercholesterolemia ☐Hyperlipidemia ☐Hypertension ☐Kidney Disease ☐Liver Disease ☐Mental Health ☐Osteoporosis ☐Seizure ☐Stroke ☐Hyperthyroidism ☐Hypothyroidism ☐TB ☐Ulcer/Stomach or GI ☐Others: _____

Past Surgical History:

☐None ☐Appendectomy ☐Breast Implant ☐Breast Reduction ☐Cataract Surgery ☐Cholecystectomy ☐Colectomy ☐Gastric Bypass ☐Hemorrhoidectomy ☐Hernia Repair ☐Mastectomy ☐Sinus Surgery ☐Tonsillectomy ☐Tummy Tuck ☐Others: _____

Drug Allergy: ☐None ☐Yes: _____

Medical History Form

Name: _____ Date of Birth: _____ Today's date: _____

Social History:

☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Occupation: _____

☐Smoking: ____packs per day for _____ years ☐Drug Use: specify drugs & amount _____

☐Alcohol Use: amount per day _____for years_____ ☐Exercise: How much & how often: _____

☐Number of sexual partner in life: _____

Family History: ☐None

	Father	Mother	Brothers/Sisters		Sons/Daughters		Cousins	Aunts/Uncles	
Healthy/ Alive	☐	☐	☐	☐	☐	☐			
Deceased	☐	☐	☐	☐	☐	☐			
Cancer: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Disease:_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease:_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIV	☐	☐	☐	☐	☐	☐	☐	☐	☐
GI Disease: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure	☐	☐	☐	☐	☐	☐	☐	☐	☐
DVT	☐	☐	☐	☐	☐	☐	☐	☐	☐
Others: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

Review of Systems: ☐None **♥Gen:**☐Fever/Chills ☐Appetite Loss ☐Weight Gain ☐Weight Loss ☐Fatigue **♥EYE:**☐Vision Loss ☐Blurred Vision ☐Eye Irritation ☐Eye Pain **♥ENT:**☐Decreased Hearing ☐Nasal Congestion ☐Nose Bleed ☐Sore Throat **♥CV:**☐Chest Pain ☐Irregular Heart Beat ☐Short of Breath ☐Palpitation ☐Leg Cramps with Exertion **♥RESP:**☐Cough ☐Wheezing **♥GI:**☐Heart Burn ☐Nausea ☐Vomiting ☐Abdominal Pain/Bloating ☐Hemorrhoid ☐Diarrhea ☐Constipation ☐Change of Bowel Habit ☐Tarry Stool ☐Bloody Stool ☐Stool Incontinence **♥GU:**☐Missed period ☐Excessive Period ☐Pelvic Pain ☐Vaginal Discharge ☐Vulva/Vaginal Itching ☐Dysmenorrhea ☐Dyspareunia ☐Dysuria ☐PMS ☐Frequent Urination ☐Hematuria ☐Urinary Incontinence ☐Nocturia ☐Vaginal Spotting ☐Vaginal Bleeding **♥ MSK:**☐Joint Pain ☐Back Pain **♥SKIN:**☐Night Sweat ☐Skin Rash ☐Skin Itching ☐Skin Ulcer **♥NEURO:**☐Headache ☐Faints ☐Seizures **♥PSYCH:**☐Anxiety ☐Nervousness ☐Depression ☐Suicide Ideation ☐Insomnia **♥ENDO:**☐Hot Flush ☐Cold Sweat ☐Night Sweat **♥HEMA:**☐Enlarged Lymph Node ☐Bruise ☐Anemia ☐Others:_____

Medications: Please list all of your current prescription & nonprescription medications, vitamins & supplements:

☐None ☐See Attached

Family History Patient Questionnaire

Name:_____

Instructions: Please circle Y to those that apply to **you** and/or **your family** on your mother OR father's side.

HEREDITARY BREAST and OVARIAN CANCER SYNDROME

Y	N	-	**Breast cancer before age 50**	-or-
Y	N	-	**Ovarian cancer at any age**	-or-
Y	N	-	**Bilateral breast cancer at any age**	-or-
Y	N	-	**Both breast cancer and ovarian cancer at any age**	-or-
Y	N	-	**Male breast cancer at any age**	-or-
Y	N	-	**Ashkenazi Jewish ancestry with breast or ovarian cancer at any age**	

HEREDITARY NONPOLYPOSIS COLORECTAL CANCER SYNDROME

Y	N	-	**Colorectal cancer before age 50**	-or-
Y	N	-	**Endometrial cancer before age 50**	-or-
Y	N	-	**Colorectal cancer after age 50 and a family member diagnosed with any of these cancers*? (see below and please circle those that apply)**	

***Cancers: colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenoma**

If you checked yes in one or more boxes on the Family History Questionnaire ask your doctor to assess your cancer history. If your history indicates that you may have an inherited risk of cancer, there is a blood test that can help determine if you are at risk for hereditary cancer.

Please talk to your doctor about reducing your risk and possibly preventing cancer.

Yat-Min Chen, M.D.
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INFORMED CONSENT FORM FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) TEST

1. AIDS (Acquired Immunodeficiency Syndrome) is a severe breakdown in the body's ability to defend itself against disease. It is caused by the Human Immunodeficiency Virus(HIV).

2. I have been advised by my physician to have a blood test to detect the presence or absence of the antibodies to the Human Immunodeficiency Virus (HIV). I have been advised that the procedure which involves the withdrawal by needle of a small amount of blood for laboratory testing, (about 1 1/2 tablespoons), may cause some slight discomfort at the site of entry of the needle, and that the procedure has minimal risks, such as bruising, soreness, and a slight risk of infection.

3. I have been provided with information about exposure to and the prevention and transmission of AIDS, the HIV antibody test and about test results and what they mean. I understand that my physician and/or another designated health care provider will discuss my test results with me in person and provide for follow-up counseling and referral to support services if necessary.

4. I have been informed that if I consent to have this test done, the results of this test will be recorded in my health record and persons involved in my health care will have access to the test results. I understand that the results of the HIV antibody test are considered confidential and that the test results in my health record shall not be released without my written permission, except to the individuals and organizations that have been given access by law who also are required to keep my health record information confidential.

5. I have been informed that if I declined permission for this test. Decisions to take infectious disease precautions will be made on the basis of other medical information concerning me. If I do not consent to the HIV antibody test, I agree to assume all risks that may result from my refusal to consent. I also agree not to hold my physician(s) or any other personnel responsible for any adverse results that may arise from my refusal to consent to the HIV antibody test.

6. I have been given the opportunity to ask any questions that I may have concerning AIDS, the HIV antibody test, its limitations, confidentiality, and its alternatives before consenting to the HIV antibody test. I understand the implications of the HIV antibody test and consent to the performance of this test.

7. I authorize the forwarding of my name, address, birth date, the name of the medical test(s) and charges to my insurance company, Medicaid, or other medical assistance programs.

8. I further understand that if I consent to the release of any of my medical records to any person or payer, the HIV antibody test results are included in the medical results.

I _____ have read and understand the above statements.

_____ _____
Patient's Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
Witness Signature Date

I decline to have the HIV antibody test: _____
Patient's Signature

DR. CHEN OB/GYN, P.A.

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Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Taking and utilization of cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **The consent will remain in full force until revoked in writing.**

I understand that Dr. Chen OB/GYN, P.A. includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Dr. Chen OB/GYN, P.A. may use my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Dr. Chen OB/GYN, P.A. of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered by this authorization. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Dr. Chen OB/GYN, P.A./ Yat-Min Chen, M.D.

I acknowledge that I have been given the Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Patient (or Responsible Party) Print Name

_____ _____/_____/_____

Patient (or Responsible Party) Signature ***Date***

Dr. Chen OB/GYN P.A.

Yat-Min Chen, M.D.; F.A.C.O.G.
Kir-Wei Chen, M.D.
Board Certified in American Board of Obstetrics and Gynecology
5350 W. Hillsboro Boulevard, Suite 102, Coconut Creek, FL 33073
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To My Patients:

Due to the high costs of Medical Liability Insurance I have chosen not to carry it. I refuse to increase my fees to pay the high insurance company premiums.

Dr. Kir-Wei Chen is an independent contractor health care provider with Dr. Chen OB/GYN, P.A.

Yat-Min Chen, M.D.; F.A.C.O.G.

Kir-Wei Chen, M.D.

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

By signing below, I acknowledged & fully understand it.

Patient Signature (or Parent/ Guardian) Date

Dr. Chen OB/GYN P.A.

Yat-Min Chen, M.D.; F.A.C.O.G.
Board Certified in American board of Obstetrics and Gynecology
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Coconut Creek, FL 33063
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In order to improve the patient service, we need your cooperation.

APPOINTMENT CANCELLATION POLICY

By signing below, I agree to give the office the advance cancellation notice **at least 24 hours before my appointment,** in case I cannot keep the appointment. Otherwise I agree to pay **$25.00 surcharge.**

如果我要取消預約，我必須在 **24** 小時前通知診所，否則我同意**$25.00** 的附加費。

Patient Signature: _____ Date: _____

Patient Print Name:_____

PATIENT SAFETY POLICY

For the patient safety and to improve the tracking & reminder, I am informed that I **should call the office for the result** on the Tuesday or Friday **about two weeks after** my laboratory test &/or radiology test.

我需在檢驗兩週後的星期二或星期五詢問診所我的血液，子宮頸抹片，切片，採撿，放射線檢驗等等的結果報告。

Patient Signature: _____ Date: _____

Patient Print Name: _____