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 醫病史

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

Chief Complaint: 主訴_____

Obstetric & Gynecology History婦產科病史: Please list method as請標明產法: **C/Section**剖腹產, Vaginal **(SVD)**自然產, Miscarriage **(Sp. Ab)**流產, Termination of Pregnancy **(TOP)**墮胎, **D&C**刮宮; also Gestational Age **(GA)**孕期 as **weeks**周數 or **months**月數.

	Month/ Year 月/年	GA wks/months 周數	Method 產法	Complication 併發症	Weight 出生體重	Boy/Girl 男女
1st Preg 第一胎						
2nd Preg 第二胎						
3rt Preg 第三胎						
4th Preg 第四胎						
5th Preg 第五胎						
6th Preg 第六胎						
7th Preg 第七胎						
8th Preg 第八胎						

Menstruation History月經史:

Age of 1st period **(Menarche)**初經歲數: ____ y/o; **Interval** between 1st day of each period月經週期: _____ days;

Duration of each period last月經天數: _____ days; **Regular** cycle or not月經規律否: ☐yes, ☐no.

Menopause停經歲數: at age of _____ y/o; ☐Natural自然, ☐Total Abdominal Hysterectomy腹部子宮全切除,

☐Total Vaginal Hysterectomy陰道子宮切除, ☐Laparoscopic Total Hysterectomy腹腔鏡子宮全切除,

☐Laparoscopic Supracervical Hysterectomy腹腔鏡子宮局部切除, ☐Bilateral Salpingoophorectomy双側卵巢切除

Contraception避孕法: ☐None無, ☐Birth) Control Pill避孕藥, ☐Bilateral Tubal Ligation結紮, ☐Condom保險套, ☐Depoprovera Shot,

☐Implanon, ☐IUD避孕器, ☐Natural自然, ☐Nuva Ring, ☐Patch, ☐Vasectomy男性結紮, ☐Others其他: _____

History of sexual Transmitted Disease性病史: ☐None無, ☐Cervical Dysplasia子宮頸抹片異常, ☐Chlamydia披衣菌支原体,

☐Genital Warts菜花, ☐Gonorrhea淋病, ☐Hepatitis B乙型肝炎, ☐Hepatitis C丙型肝炎, ☐Herpes Simplex單純疱疹, ☐HIV

☐HPV人類乳突状病毒, ☐Syphilis梅毒, ☐VAIN/ Vaginal Dysplasia陰道細胞異常, ☐VIN/ Vulva Dysplasia陰唇細胞異常, ☐Others其他:

History of Gynecology Surgery婦科病史: ☐None無 ☐C/S剖腹產, ☐Colpopexy/ Anterior-Posterior Repair尿失禁/陰道整型

☐Cryotherapy子宮頸冷凍術 ☐D&C刮宮 ☐Ectopic Pregnancy子宮外孕 ☐Hysteroscopy子宮腔鏡 ☐Laparoscopy腹腔鏡

☐LEEP/ Cone Biopsy子宮頸圓錐切除 ☐Laparoscopic Total Hysterectomy腹腔鏡子宮全切除

☐Laparoscopic Supracevical Hysterectomy腹腔鏡子宮局部切除 ☐Ovarian Cystectomy卵巢囊腫切除 ☐Oophorectomy

☐Total Abdominal Hysterectomy腹部子宮全切除 ☐Total Vaginal Hysterectomy陰道子宮切除

☐Tubal Reversal/ Tuboplasty輸卵管再接整型術 ☐Urethropexy尿道固定術 ☐Vulvectomy陰唇切除術 ☐Others其他:_____

Past Medical History內科病史:

☐None無 ☐Abnormal Mammogram乳房攝影異常 ☐Abnormal Pap Smear宮頸抹片異常 ☐Anemia貧血 ☐Arthritis/Joint Disease關節炎

☐Asthma哮喘 ☐Breast Disease乳房疾病 ☐Cancer癌症 ☐COPD慢性阻塞性肺病 ☐Depression憂鬱症 ☐DM糖尿病 ☐DVT靜脈血栓

☐GI Disease腸胃病☐Hay Fever花粉過敏☐Hearing Loss失聰☐Hair Loss掉髮 ☐Heart Disease心臟病 ☐Hepatitis A甲肝☐Hepatitis B乙肝

☐Hepatitis C丙肝 ☐HIV愛滋 ☐Hypercholesterolemia高胆固醇 ☐Hyperlipidemia高血脂 ☐Hypertension高血壓 ☐Kidney Disease腎病

☐Liver Disease肝病☐Mental Health精神病 ☐Osteoporosis骨質酥鬆 ☐Seizure癲癇 ☐Stroke中風 ☐Hyperthyroidism甲亢

☐Hypothyroidism甲状腺功能減退☐TB肺結核 ☐Ulcer/Stomach or GI腸胃潰瘍 ☐Others其他: _____

Past Surgical History外科病史:

☐None無 ☐Appendectomy盲腸炎 ☐Breast Implant隆乳 ☐Breast Reduction縮乳 ☐Cataract Surgery白內障 ☐Cholecystectomy除胆切

☐Colectomy大腸切除 ☐Gastric Bypass胃繞道 ☐Hemorrhoidectomy痔切除 ☐Hernia Repair疝氣手術 ☐Mastectomy乳房切除☐Sinus

Surgery瘻管切除 ☐Tonsillectomy扁桃腺切除 ☐Tummy Tuck腹部除皺 ☐Others其他: _____

Drug Allergy藥物過敏: _____

Medical History Form

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

Social History:

☐Married已婚 ☐Single單身 ☐Divorced離婚 ☐Separated分居 ☐Widowed寡 ☐Occupation職業_____

☐Smoking抽烟: ____packs per day for _____ years ☐Drug Use非法藥物: specify drugs & amount _____

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

☐Number of sexual partner in life性伴侶總數: _____

Family History家族史: ☐None無

	Father父	Mother母	Brothers/Sisters手足		Sons/Daughters子女		Cousins堂表	Aunts/Uncles姑姨伯舅	
Healthy/ Alive健在	☐	☐	☐	☐	☐	☐			
Deceased過逝	☐	☐	☐	☐	☐	☐			
Cancer 癌症: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes糖尿病	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke中風	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension高血壓	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma哮喘	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Disease乳房疾病:_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease心臟病: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis肝炎: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIV愛滋	☐	☐	☐	☐	☐	☐	☐	☐	☐
GI Disease腸胃病: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease腎病: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease甲状腺: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure癲痫	☐	☐	☐	☐	☐	☐	☐	☐	☐
DVT靜脈血栓	☐	☐	☐	☐	☐	☐	☐	☐	☐
Others其他: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

Review of Systems系統症状: ☐None無 ♥**Gen:**☐Fever/Chills發燒發冷, ☐Appetite Loss沒食慾,☐Weight Gain增肥, ☐Weight Loss減重, ☐Fatigue疲勞 ♥**EYE:**☐Vision Loss失明, ☐Blurred Vision視力模糊, ☐Eye Irritation, ☐Eye Pain眼痛 ♥**ENT:**☐Decreased Hearing失聰, ☐Nasal Congestion鼻塞, ☐Nose Bleed鼻血, ☐Sore Throat 喉痛 ♥**CV:**☐Chest Pain胸痛, ☐Irregular Heart Beat心律不準 ☐ short of Breath氣短, ☐Palpitation心悸, ☐Leg Cramps with Exertion腳抽筋 ♥**RESP:**☐Cough咳, ☐Wheezing哮喘, ♥**GI:**☐Heart Burn胃酸, ☐Nausea噁, ☐Vomiting吐, ☐Abdominal Pain/Bloating腹痛脹, ☐Hemorrhoid痔, ☐Diarrhea腹瀉, ☐Constipation便秘, ☐Change of Bowel Habit排便習慣改變, ☐Tarry Stool黑便, ☐Bloody Stool血便, ☐Stool Incontinence大便失禁 ♥**GU:**☐Missed period沒月經 ☐Excessive Period月經過多, ☐Pelvic Pain骨盆腔痛, ☐Vaginal Discharge白帶, ☐Vulva/Vaginal Itching陰部癢, ☐Dysmenorrhea痛經 ☐Dyspareunia性交疼痛, ☐Dysuria小便痛, ☐PMS經前症候, ☐Frequent Urination頻尿, ☐Hematuria血尿, ☐Urinary Incontinence尿失禁 ☐Nocturia夜尿, ☐Vaginal Spotting陰道点血, ☐Vaginal Bleeding陰道出血 ♥ **MSK:**☐Joint Pain関節痛, ☐Back Pain背痛, ♥**SKIN:**☐Skin Rash皮疹, ☐Skin Itching皮癢, ☐Skin Ulcer皮潰瘍 ♥**NEURO:**☐Headache頭痛, ☐Faints暈, ☐Seizures癲痫 ♥**PSYCH:**☐Anxiety焦慮 ☐Nervousness緊張, ☐Depression憂鬱, ☐Suicide Ideation自殺意念, ☐Insomnia失眠 ♥**ENDO:**☐Hot Flush潮熱, ☐Cold Sweat冷汗 ☐Night Sweat盜汗, ♥**HEMA:**☐Enlarged Lymph Node淋巴腫, ☐Bruise瘀青, ☐Anemia貧血, ☐Others其他:_____

Medications目前使用藥品: Please list all of your current prescription & nonprescription medications, vitamins etc.:

☐None無, ☐See Attached見附表

Dr.Chen OB/GYNP.A._____

Patient Name:_____ Date: _____/_____/_____

婦女泌尿系統自我問答

1. 在睡眠中或白天.妳是否曾突然尿失禁?

☺是 ☺否

2. 妳是否曾在咳嗽.打噴嚏.跳躍或用力時.突然漏尿?

☺是 ☺否

3. 妳是否曾有突然尿急的感覺?

☺是 ☺否

4. 妳有否頻尿?

☺是 ☺否

5. 妳一天小便有否超過八次?

☺是 ☺否

6. 妳半夜起床小便有否超過二次?

☺是 ☺否

7. 當妳外出或旅遊時有無廁所方便使用是否會影响妳外出的決定?

☺是 ☺否

Dr.Chen OB/GYNP.A._____

Patient Name:_____ Date: _____/_____/_____

乳癌卵巢癌大腸癌家族史問答

§ 遺傳性乳癌卵巢癌症候群

家族是否有人:

五十歲前患有乳癌————是 否
患有卵巢癌————是 否
双乳皆患有乳癌————是 否
男性患有乳癌————是 否
猶太血統且患有乳癌或卵巢癌————是 否

§ 遺傳性非蠮肉狀大腸直腸癌症候群

家族是否有人:

五十歲前患有大腸直腸癌————是 否
五十歲前患有子宮內膜癌————是 否
五十歲後患有大腸直腸癌, 且家族有下列任一癌症: (請圈选)
大腸直腸癌, 子宮內膜癌, 胃癌, 卵巢癌, 輸尿管癌, 腎盂癌,
胆管癌, 小腸癌, 胰臟癌, 腦癌, 皮脂腺癌

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.

5350 W. Hillsboro Boulevard, Suite 102, Coconut Creek, FL 33073
Tel. (954) 725-7660 Fax: (954) 725-7605

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

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
5350 W. Hillsboro Blvd.
Suite 102
Coconut Creek, FL 33063
Tel: (954) 725-7660 Fax: (954) 725-7605

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: _____