FOREVER CARE OB/GYN

Date(日期):

Appt. Time:__________ Time In:__________

Patient Name (名字): __________ **DATE OF BIRTH（生日）:** __________ **Age(年龄):** ___

Address（地址）: __________

City(城市): __________ State（州）: __________ Zip Code（邮编）: __________

Home Phone（家庭电话）: __________ Cell Phone（移动电话）: __________

Emergency Contact（紧急联系人）: Name（名字）: __________ Phone（电话）: __________

☐ Agree Text Reminder (同意文字提示) ☐ Voice Reminder(同意语音提示)

Social Security NO. (社安号)(Required for Insurance Patients（有保险的病人需要）): __________

Insurance Company（保险公司）: __________

Email Address（电子邮件）: __________

***Patient Portal: If you give us email address, we will provide you online access account with which you can access to your result, communicate with us.**

Pharmacy Name(药房名称): __________

Address（药房地址）: __________

Phone（药房电话）: __________

City（城市）: __________ State（州）: __________ Zip code（邮编）: __________

PERMISSION TO RELEASE INFORMATION

I, __________, hereby authorize Forever Care OB/GYN to release any or all Medical Information and test results that pertain to me to the individual listed below.

Name: __________ Phone: __________

I am a Family Member: __________ ☐ I have the Power of Attorney ☐ I have a Non-Family Caregiver.

HOW DID YOU FIND US? Please Circle

SEARCH FRIEND NEWS PAPER ZOCDOC OTHER: __________

Patient Signature（签名）	DATE（日期）

Protected Health Information

The (H.I.P.A.A) Health Insurance Portability & Accountability Act of 1996 has created a new national standard to protect individual medical records & other personal health information.

I allow Forever Care OB/GYN to disclose pertinent health care information to other providers, labs, hospitals, as well as insurance companies, billing clearing houses as needed to obtain payment for services and to aid in healthcare as deemed by the physician. Forever Care OB/GYN will make every effort to limit the use, disclosure of, and requests to minimum necessary to accomplish the individual purpose

Forever Care OB/GYN WILL NOT sell my name to a mailing list, disclose information to an employment decisions or disclose information for eligibility for life insurance without signed authorization form written on a company letterhead. All I requests for the release of medical records must be in writing.

Consent for payment

I hereby irrevocably assign and transfer to Forever Care OB/GYN and treating physicians all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, under ay third-party actions against any other person or entity, or under any other benefit plan or program (hereafter referred to as Benefits) for this clinical visits. I understand and acknowledge that this assignment does not relieve me of my financial responsibility for all clinical charges and treating physicians charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimburse to Forever Care OB/GYN and treating physicians by any benefit plan or program. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment of services rendered.

MEDICARE/MEDICAID SIGNATURE ON FILE:

I request that payment of authorized Medicare/Medicaid benefits be made to Shirley Xuan Cao on my behalf for any services furnished to me by the physician practice named above. I authorize any holder of information about me to release to the health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Consent for Procedure and Treatments

I consent to treatment by Forever Care OB/GYN and authorize all routine clinical activities, treatments, examinations, and diagnostic services. These procedures may be performed by physicians, nurses technicians, physician assistants or other healthcare professionals. While routinely performed without incident, there may be material risks associated with each of these procedures.

Patient Name（姓名）： DATE OF BIRTH（出生日期）： Age（年龄）：

对于下列问题如果回答yes的话，麻烦请用手机把您的回答翻译成英文，谢谢^-^!

1) Have you ever had any remarkable major events such as hospitalizations, surgeries (您是否有过病史如住院手术等)?（Y / N）
____
____
2) Have any allergy to medications(您有任何药物过敏吗)?（Y / N）
____
3) Current Medical problems(是否有长期医疗问题例如糖尿病，高血压等)?（Y / N）
____
4) Please List your current medicine if you did not bring in medicines or list today（如果您没有携带药物或者列表，请列出您最近正在服用的药物）?（Y / N）
____
____
5) Please list family medical history（请列出家族病史）?（Y / N）
____
____
6) Do you smoke, drink alcohol or use any recreational substances (illicit drugs)（您吸烟，喝酒或者使用任何娱乐性质（非法药物）吗）？ ☐ Yes ☐ No
7) Marital Status（婚姻状况）? ☐ Single（单身） ☐ Married（已婚） ☐ Live alone（独居） ☐ Live with spouse（和配偶一起生活）
8) Did you ever done Colonoscopy (您之前有做过肠镜吗？（Y / N）)(colon cancer exam endoscopy比如结肠癌检查或内镜检查)? If so When（如果做过的话是什么时候做的）? ____________
9) Did you ever have Shingles Shot, Hep-B, Pneumo vaccinated? If so when? ____________
10) Are you Pregnant(您现在有怀孕吗)? ☐ Yes ☐ No
11) When was your last pap smear（您上次什么时候做的宫颈抹片）? ____________
12) How many children do you have?(请问您有几个孩子，男孩女孩？) ____________
13) When was you last menstrual period?（您上次月经是什么时候？） ____________
14) Ever done any gynecologic surgery such as hysterectomy or tube tied（您曾经做过任何妇科手术吗？比如子宫切除术，输卵管结扎等）? ____________
15) When was your last mammogram（请问您之前是否做过乳腺x光的检查，什么时候）? ____________
16) How many Miscarriage or abortion（请问您之前有流产过吗）? ______ Miscarriage（非自主流产） ______ Abortion（人工流产）

____

Please Continue

I understand and agree to sign for that:

- **The practice of medicine is not an exact science and that NO GURANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any Procedure;**
- **The healthcare professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me , in determining whether to perform or recommend the procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions;**
- **I may withdraw my consent for any test pr procedure at any time.**
- **I consent to healthcare professionals performing procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not know to be needed at the time this consent is obtained;**
- **I consent to the disposal by hospital authorities of any specimens, tissue or parts that may removed from my body during my hospitalization.**

By signing, I authorize Forever Care OB/GYN to send certain protected health information (PHI) by mail, fax, or text message if chosen. I understand the insecurity of the mail or fax correspondence. By signing this authorization form, I waive any legal responsibility to Forever Care OB/GYN for any unintended exposure of information incurred once mailed/faxed. I will not hold Forever Care OB/GYN responsible any charges I may incur from my wireless carrier from phone calls and/or text messages

X ______________________________ ______________

Patient/Patients Representative (Specify the relationship) （签名） **Date（日期）**

Reason patient is unable to sign:

____

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