Dallas E&W OB/GYN Clinic Patient Registration 환자 접수 서류

환자 관련 정보

본명 **Name:** _____ 소셜 번호 **SS # :** _____

영어 이름 **:**_____ 나이**:** _____ 생년월일 **/DOB:** _____

주소 **:** _____아파트**#**_____시 **:**_____

주 **ST :** _____ 우편번호 **:** _____핸드폰 번호 **CELL #:** _____

집 전화번호 **HOME# :** _____ 직장 전화번호 **WORK # :** _____

* 검사결과를 통보 받기 원하는 전화번호 **BEST NUMBER TO CALL WITH RESULTS:** _____

* 메세지를 남겨도 괜찮나요? **OK TO LEAVE VOICE MAIL / TEXT MESSAGE?** 네 **(Y)** _____ 아니요 **(N)** _____

혼인 여부 **Marital status :** 미혼**(Single)**_____기혼**(Married)** _____ 이혼**(Divorced)** _____ 기타**(Other)** _____

어떻게 알고 오셨나요**? Referred by:**_____지정 주치의**(내과) PCP:**_____전화번호 **:** _____

약국이름 **Pharmacy :** _____ 전화번호 **Phone # :** _____

비상 연락처 이름 **Emergency contact :** _____ 환자와의 관계 **Relationship** _____

비상 연락처 전화번호 **Phone # :** _____

보험 계약자 정보 / PRIMARY INSURANCE HOLDER (보험 보유시 작성해 주세요)

보험 계약자 이름 **Policy holder :** _____ 소셜번호 **SS# :** _____

생년월일 **DOB:**_____환자와의 관계**:** 본인 **SELF**_____배우자 **SPOUSE** _____ 부모 **PARENT** _____기타 **OTHER**_____

주소 **Address :**_____ 시 **City :** _____ 주 **ST :** _____ 우편번호**/Zip:** _____
(위의 주소와 동일하지 않으시면 작성해 주세요)

집 전화번호 **Home phone # :** _____ 핸드폰 번호 **Cell # :** _____

이차 보험 정보**(Secondary Insurance)** (추가 보험 보유시)

보험 계약자 이름 **Policy holder :** _____ 생년월일 **DOB :** _____

집 전화번호 **Home phone #:** _____ 핸드폰 번호 **Cell # :** _____

I hereby assign all medical and /or surgical benefits, to include major surgery benefits to which I am entitled, including private insurance and any other health plan, to Dallas E&W OB/GYN Clinic. I authorize the release of medical information necessary to request reimbursement from insurance companies. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. A photocopy of this assignment is to be considered as valid as the original. I also understand that if my payment hasn't been made from my insurance company in 60 days, it will be my responsibility to contact the insurance company and make sure payment is made in a timely manner. I understand that any overpayment on my account will be promptly credited or refunded. I also understand that the quote from my insurance company does not guarantee payment. The actual payment amount will be determined when my explanation of benefits is received. Consent to receive treatment: I hereby authorize the physician to treat myself or if a minor, my daughter, as deemed medically necessary.

서명**(Signature):** _____ 날짜**(Date):** _____

Medical History 병력

Name 성명:_____Age 나이:_____

(Check all that applies 본인과 가족의 병력에 해당되는 사항을 기재해 주세요)

본인 / 가족 Self / Family			본인 / 가족 Self / Family		
( )	( )	빈혈/혈액질환 Anemia/Blood Disease	( )	( )	관절염/골다공증 Arthritis/Osteoporosis
( )	( )	고혈압 Hypertension/Stroke	( )	( )	다리에 혈전여부 Blood Clots in Legs
( )	( )	심장질환 Heart Disease	( )	( )	자궁근종 Uterine Fibroids
( )	( )	고콜레스테롤 Hyper Cholesterol	( )	( )	자궁내막증 Endometriosis
( )	( )	당뇨병 Diabetes	( )	( )	과 출혈/부정출혈 월경증상 Heavy/Irre. Periods
( )	( )	우울증/불안증 Depression/Anxiety	( )	( )	유방종양/유방통 Breast Mass/Breast Pain
( )	( )	갑상선증 Thyroid Disease	( )	( )	간질/뇌 관련질환 Epilepsy/Neural Disease
( )	( )	천식/호흡기 질환 Asthma/Lung Disease	( )	( )	요실금/방광염 Urinary Incontinence/Infection
( )	( )	간염/간 질환 Hepatitis/Liver Disease	( )	( )	자궁탈출증 Uterine Prolapse
( )	( )	담낭 증 Gall Bladder Disease	( )	( )	암 히스토리 유무 History of Cancer
( )	( )	신장 질환 Kidney Disease	( )	( )	과도한 몸무게 증가/빠짐 Excessive weight Gain/Loss
( )	( )	배변문제			
( )	( )	배변문제	( )	( )	성병 유무 Sexual Transmitted Disease

키: _____ **평상시 몸무게:** _____ **파운드/킬로그램**

List of Surgeries (if any) 수술 목록

Date/날짜	병명
_____	_____
_____	_____
_____	_____

Current Medications/현재 복용중인 약명들:

_____

_____

Medication Allergies (if any)/약 알러지 유무: _____

Alcohol(술**)** YES/NO **Smoking(**담배**)** YES/NO **Drug use(**약**)** YES/NO **Exercise(**운동**)** YES/NO

IMMUNIZATION STATUS (예방접종 상황):

Hepatitis B(B 형간염): YES NO ? CARRIER(*B 형 간염 보균자*) _____

Hepatitis A(A 형간염): YES NO ?

Gardasil (HPV Vaccine)(인유두종 바이러스 예방주사): YES NO ?

⇨ for preventing cervical, vaginal, vulvar cancer in females

MENSTRUAL HISTORY (월경 기록)**:**

Age of first period? (초경을 시작한 나이) **:** _____

Days of flow/bleeding (월경기간)**:**_____ Cramps (생리통이 있으신가요)**?** ( )네 ( )아니요

[1st day of last period (가장 최근 월경 첫일)**:** _____ ( ) 확실치 않음 Unsure ( )폐경 Menopause

# of days between periods (월경주기)**:** _____ Age of menopause (폐경을 맞은 나이)**:**_____

Flow (check applicable) (월경시 혈액양)**:** ( ) 조금 light ( ) 보통 medium ( ) 많이 heavy ( ) 덩어리 clots

Pre- (PMS)(월경전증후군)**:** ( )네 ( )아니요

Period pattern (월경주기) **:** ( )규칙적 Regular ( )불규칙적 Irregular

C*omments*(추가설명)*:*

_____

of **PREGNANCIES** (총임신횟수) ***(if applicable)*****:**_____

만삭 임신횟수: _____ 조산 횟수: _____ 유산/낙태: _____ 자녀: _____

	출생날짜	임신기간	자연분만/제왕절개	특이점
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Any complications? (*please explain*) *만일 난산이셨다면 추가 설명해주세요*:

_____

_____

Answer Yes or No (if Y, please include <u>latest date</u>) ***가장 최근에*** 검사 하신 날짜를 기입해 주세요

Pap smear 자궁 경부암 검사**:** _____ 결과: ( ) Normal 정상 / ( ) Abnormal 비정상

Mammogram 유방암 검사: _____ **Bone Density Test** 골밀도검사**:** _____

General health panel 정기 혈액검사**:** _____ **Pelvic sonogram** 질 초음파 검사: _____

Colonoscopy 대장내시경검사**:** _____

Current method of birth control 현재 사용하는 피임기구**:** _____

Do you need any information about birth control? ( ) YES ( ) NO
피임기구에 관한 정보가 필요하시나요?

Reason for your visit? 방문 목적 **:** _____

_____

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Plano, TX 75093

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Fax: 972-378-9888

Confidentiality

Authorization of Use / Disclosure of Health Information

I acknowledge that a copy of Dallas E & W OB/GYN Clinic's HIPAA Notice of Privacy Practices is available to me, which explains how my medical information will be used and disclosed.

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than listed in the "Notice of Privacy Practices" will require your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke will not affect or undo any disclosure prior to your notification date. You have the right to request restrictions on use and disclosure of your health information.

Note: If I have provided e-mail addresses for my Preferred Contacts, my signature below indicates that I understand and acknowledge that e-mail communication is not secure. E-mail can be intercepted during transmission; and Unencrypted messages (and any attachments) can be read and potentially copied and forwarded by anyone. Unencrypted e-mails can be easily viewed by someone other than the recipient if, for example, I access messages via a smart phone or tablet.

➔ _____

Print Patient Name **Date of Birth**

➔ _____

Signature of Patient **Date**

_____

Patient Representative /Legal Guardian **Relationship to Patient**

E-Mail: _____

Authorized Person to discuss your medical condition:

_____

Name of Person **Relationship** **Phone #**

_____

Name of Person **Relationship** **Phone #**