Chang Lee M.D.
399 E Highland Ave #223
San Bernardino, CA 92404
Tel: 909-475-5200

OBSTETRICS INFORMATION SHEET

Please complete these forms and return it to the receptionist. Thank you. (Por Favor llene y firme estas formas. Regrese estas formas a la recepcionista cuando termine. Gracias)

DATE (FECHA) _____/_____/_____ GENDER -- MALE / FEMALE

1. PATIENT INFORMATION

LAST NAME (APELLIDO): _____FIRST NAME (NOMBRE):_____
PRIMARY LANGUAGE _____ DO YOU NEED A TRANSLATER? YES OR NO

ADDRESS (DOMICILIO): _____
CITY/STATE/ZIP (CUIDAD, ESTADO, CODIGO POSTAL) _____
_____**TELEPHONE** (TELEFONO) (_____)_____
CELL PHONE NUMBER (_____)_____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #_____-_____-_____
(FECHA DE NACIMIENTO) (# DE SEGURO SOCIAL)
SINGLE (SOLTERA)_____ MARRIED (CASADA)_____ DIVORCED (DIVORCIADA)_____
WIDOWED (VIUDA)_____ SEPARATED (SEPERADA)_____ MINOR (MENOR DE EDAD)_____

EMPLOYER (EMPLEADOR) _____
EMPLOYER PHONE NUMBER (NUMERO DE TELEFONO DE EMPLEADOR): (_____)_____
OCCUPATION (OCUPASION)_____

EMERGENCY CONTACT - IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? (EN CASO DE UNA EMERGENCIA, A QUIEN DEBEMOS LLAMAR?)
NAME (NOMBRE) _____
RELATIONSHIP TO PATIENT (RELACION CON EL PACIENTE):_____
HOME TELEPHONE NUMBER (NUMERO DE CASA): (_____)_____
WORK TELEPHONE NUMBER (NUMERO DE EL TRABAJO: (_____)_____

2. RESPONSIBLE PARTY (PERSONA RESPONSIBLE):
NAME (NOMBRE) _____D.O.B (FECHA DE NACIMIENTO____/_____/____
RELATIONSHIP TO PATIENT (RELACION CON EL PACIENTE)_____
OCCUPATION (OCUPASION) _____
SS# (SEGURO SOCIAL) _____/_____/_____

3. INSURANCE INFORMATION (INFORMACION DE SU ASEGURANZA)
NAME OF INSURED (NOMBRE DE QUIEN LE PERTENECE LA ASEGURANZA)
_____
NAME OF INSURANCE: _____ POLICY #_____ GROUP #_____
(NOMBRE DE ASEGURANZA) # DE POLISA

4. AUTHORIZATION AND RELEASE (AUTORIZACION):
I HEREBY CONSENT TO AND AUTHORIZE THE ADMINISTRATION OF ALL DIAGNOSTIC AND THERAPEUTIC TREATMENTS THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGMENT OF THE ATTENDING PHYSICIAN. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT.
I (PATIENT OF GUARDIAN) AM AN ELIGIBLE MEMBER OF THIS DATE OF SERVICE OF A HEALTH PLAN AND A COPY OF THE BENEFITS CARD IS ATTACHED TO THIS DOCUMENT. SIGNATURE OF THE RESPONSIBLE PARTY BELOW ACKNOWLEDGES FULL FINANCIAL

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RESPONSIBILITY OR SERVICES RENDERED TO ME IF IT IS DETERMINED I AM NOT ELIGIBLE ON THE DATE OF SERVICE IN QUESTION OR IF SERVICES RENDERED IS DETERMINED TO BE NON-COVERED BENEFIT UNDER THE PLAN PROVISIONS.
I HEREBY IRREVOCABLE AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED CORPORATION/PHYSICIAN, BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE CORPORATION'S/ PHYSICIAN'S REGULAR CHARGE DUE AS A RESULT OF THIS CLAIM. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE CORPORATION/PHYSICIAN FOR CHARGES NOT COVERED.

PATIENT/GUARDIAN SIGNATURE (FIRMA DE EL PACIENTE O PADRES SI ES MENOR DE EDAD) _____ DATE (FECHA)_____

5. CONSENT FOR TESTING BLOOD TO DETECT AIDS (HIV SCREENING TESTS)
I HAVE BEEN INFORMED THAT MY BLOOD WILL BE TESTED IN ORDER TO DETECT WHETHER I HAVE ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). I UNDERSTAND THAT THE TEST THAT WILL BE USED INDICATES WHETHER THERE ARE ANTIBODIES TO THE PROBABLE CAUSATIVE AGENT OF AIDS IN MY BLOOD. I UNDERSTAND THAT THE TEST IS NEW AND ITS ACCURACY AND RELIABILITY IS NOT KNOWN FOR CERTAIN. I FURTHER UNDERSTAND THAT THE TEST WILL, IN SOME CASES, INDICATE THAT A PERSON HAS AIDS WHEN THE PERSON DOES NOT AND, IN OTHER CASES, FAIL TO REVEAL WHEN A PERSON HAS AIDS.
I HAVE BEEN INFORMED THAT THE TEST IS PERFORMED BY WITHDRAWING BLOOD AND BY USING A SUBSTANCE TO TEST THE BLOOD. I ALSO HAVE BEEN INFORMED THAT CURRENTLY THERE ARE NO OTHER BLOOD TESTS THAT MAY BE USED TO IDENTIFY CASES OF AIDS AND THAT OTHER MEANS OF DIAGNOSING AIDS CAN BE USED IN CONJUNCTION WITH A BLOOD TEST.
I HAVE BEEN INFORMED THAT IF I HAVE ANY QUESTIONS REGARDING THE NATURE OF THE BLOOD TEST, ITS EXPECTED BENEFITS, ITS RISKS, AND ALTERNATIVE TEST, I MAY ASK THOSE QUESTIONS BEFORE I DECIDE WHETHER TO CONSENT TO THE BLOOD TEST.
BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE BEEN GIVEN ALL OF THE INFORMATION I DESIRE CONCERNING THE BLOOD TEST TO DETECT AIDS AND HAVE HAD ALL OF MY QUESTIONS ANSWERED. FURTHER, I ACKNOWLEDGE THAT I HAVE GIVEN CONSENT FOR THE PERFORMANCE OF A BLOOD TEST TO DETECT AIDS.

SIGNATURE (ONLY IF AGREE TO TESTING)_____DATE _____

6. DRUG TESTING CONSENT
I HEREBY AUTHORIZE ANY PHYSICIAN, LABORATORY, HOSPITAL OR MEDICAL PROFESSIONAL RETAINED BY *CHANG L. LEE M.D.* FOR SCREENING & HEALTH PURPOSES TO CONDUCT A URINE DRUG TOXICOLOGY SCREENING AND TO PROVIDE THE RESULTS TO CHANG L. LEE M.D. I ALSO RELEASE ANY PERSON AFFILIATED WITH THIS OFFICE, FROM LIABILITY THEREFORE.

SIGNATURE (ONLY IF AGREE TO TESTING) _____DATE _____

7. PROVISION FOR SUBSTITUION ON DELIVERY
IN ENGAGING *CHANG L. LEE M.D.* AS MY OBSTETRICIAN, I UNDERSTAND THAT IF HE IS UNAVAILABLE OR UNABLE FOR ANY REASON TO BE PRESENT AND TO DELIVER ME, AT THE TIME OF CONFINEMENT HE WILL MAKE A REASONABLE EFFORT TO REFER ME TO ANOTHER LICENSED PHYSICIAN TO RENDER OBSTETRICAL CARE. I AGREE TO HOLD DR. LEE FREE FROM ANY DUTY, LIABILITY OR RESPONSIBILITY IN CONNECTION WITH ANY SERVICE THAT MAY BE PERFORMED BY ANY PHYSICIAN TO WHOM HE REFERS ME OR WHOM I MAY CALL.

SIGNATURE (ONLY IF AGREE TO ABOVE STATEMENT) _____DATE _____

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8. PRENATAL DIAGNOSIS WITH ULTRASOUND

MOST BABIES ARE BORN HEALTHY. IN FACT, 97 OUT OF 100 BABIES ARE BORN HEALTHY. ANYTIME A COUPLE BECOMES PREGNANT, THERE IS A 3 TO 4 PERCENT CHANCE THAT THEIR BABY WILL HAVE A BIRTH DEFECT. MOST OF BIRTH DEFECTS ARE NOT IDENTIFIED FROM ULTRASOUND EXAMINATION. IN ADDITION, ULTRASOUND IS NOT 100% ACCURATE. FOR EXAMPLE, THE ACCURACY OF GENDER ASSIGNMENT IS 99.9%.

SIGNATURE_____ DATE_____

9. PREGNANCY OUTCOME

WE WISH YOU GOOD LUCK AND BEST OUTCOME POSSIBLE. HOWEVER, WE CANNOT GUARANTEE A GOOD OUTCOME. FOR EXAMPLE, TO DECREASE THE CHANCE OF HAVING MISCARRIAGE, ONE CAN TAKE DAILY PRENATAL VITAMINS, LIMIT EXCESSIVE LIFTING (>20LBS), STOP EXCESSIVE BENDING OR STOOPING, DECREASE INTAKE OF CAFFEINATED DRINKS, KEEP WELL-HYDRATED AND DRESS WARMLY. DESPITE ALL THOSE PREVENTATIVE MEASURES, ONE CAN STILL HAVE A MISCARRIAGE. IN FACT, THE RATE OF MISCARRIAGE IS 10-20% IN THE FIRST THREE MONTHS OF PREGNANCY.

SIGNATURE_____ DATE_____

10. PRENATAL DIAGNOSIS SCREENING QUESTIONS

1. Will you be age 35 or older when the baby is due? Yes _____ No _____
2. Name of Baby's Father? _____
3. Have you or the baby's father or anyone in either of your families ever had?
   - Down Syndrome Yes _____ No _____
   - Mongolism Yes _____ No _____
   - Spina Bifida or Meningomyecele (open spine) Yes _____ No _____
   - Hemophilia Yes _____ No _____
   - Muscular Dystrophy Yes _____ No _____
   - Mental Retardation Yes _____ No _____
4. Have you or the baby's father had a child born dead or alive with a birth defect not listed in question #3 above? Yes _____ No _____
   If yes, please explain: _____
5. Do you or the baby's father or close relatives in either of your families have any inherited genetic or chromosomal disease or disorder not listed above? Yes _____ No _____
   If yes, please explain: _____
6. Have you or the spouse of this baby's father in a previous marriage had three or more spontaneous pregnancy losses? Yes _____ No _____
7. Do you or the baby's father have any close relatives descended from Jewish people who lived in Eastern Europe? (Ashkenazis Jews)? Yes _____ No _____
8. If yes, have either you or the baby's father been screened for Tay-Sachs? Yes _____ No _____
9. If the patient of the baby's father are African American, have you or the baby's father or any close relative been screened for sickle cell trait and found to be positive? Yes _____ No _____
10. Have you ever had Genital Herpes? Yes _____ No _____
11. Did you have any illness with a high fever during the month you got pregnant of the first month after? Yes _____ No _____
12. Did you take any medication for any reasons? Yes _____ No _____
    If yes. what type of medications? (Include Aspirin, Tylenol, Etc)

_____