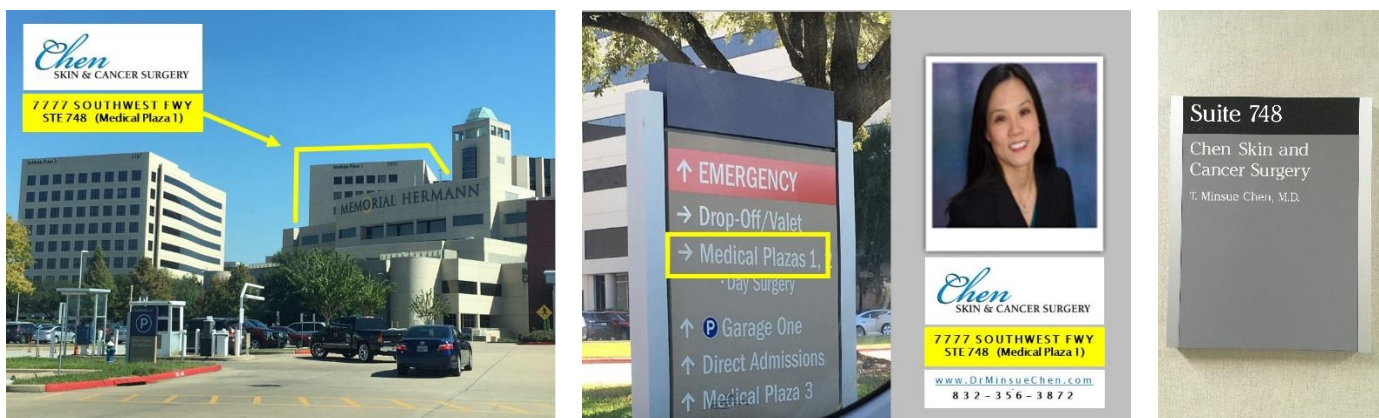


## NEW PATIENT WELCOME LETTER

**We respect your time:** In order for you (and the other patients on the schedule) to be seen with minimal wait, patient registration and paperwork must be completed **BEFORE** your appointment time. Therefore, **plan to arrive at least 15 minutes before your scheduled appointment time.** To expedite the process, **NEW PATIENT forms** can be printed and completed before your office visit. To prevent other delays, have your driver's license, insurance card, and payment ready when you check in.

**Tips on finding our office:** Our address is: **7777 Southwest Fwy, Ste 748, Houston, TX 77074.** Take the elevator to the seventh floor of **Medical Plaza 1.** CHEN SKIN AND CANCER SURGERY, P.A. is located adjacent to the Ladies Restroom.



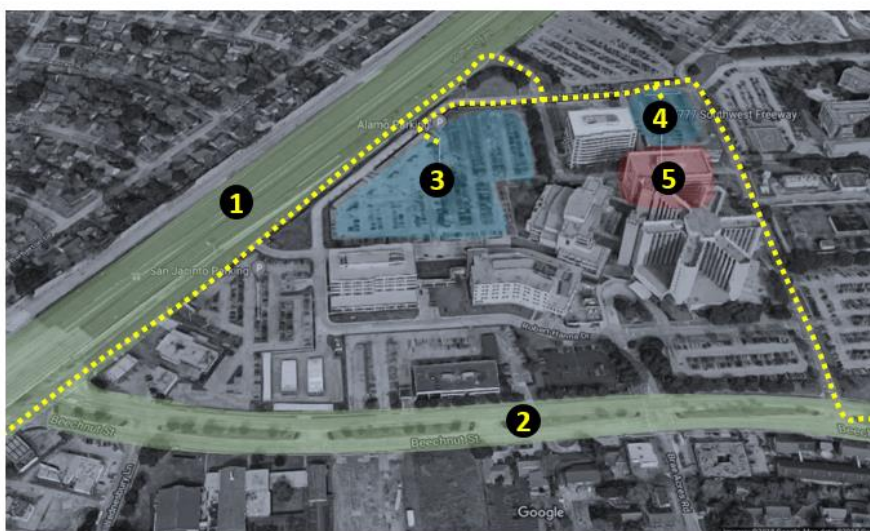
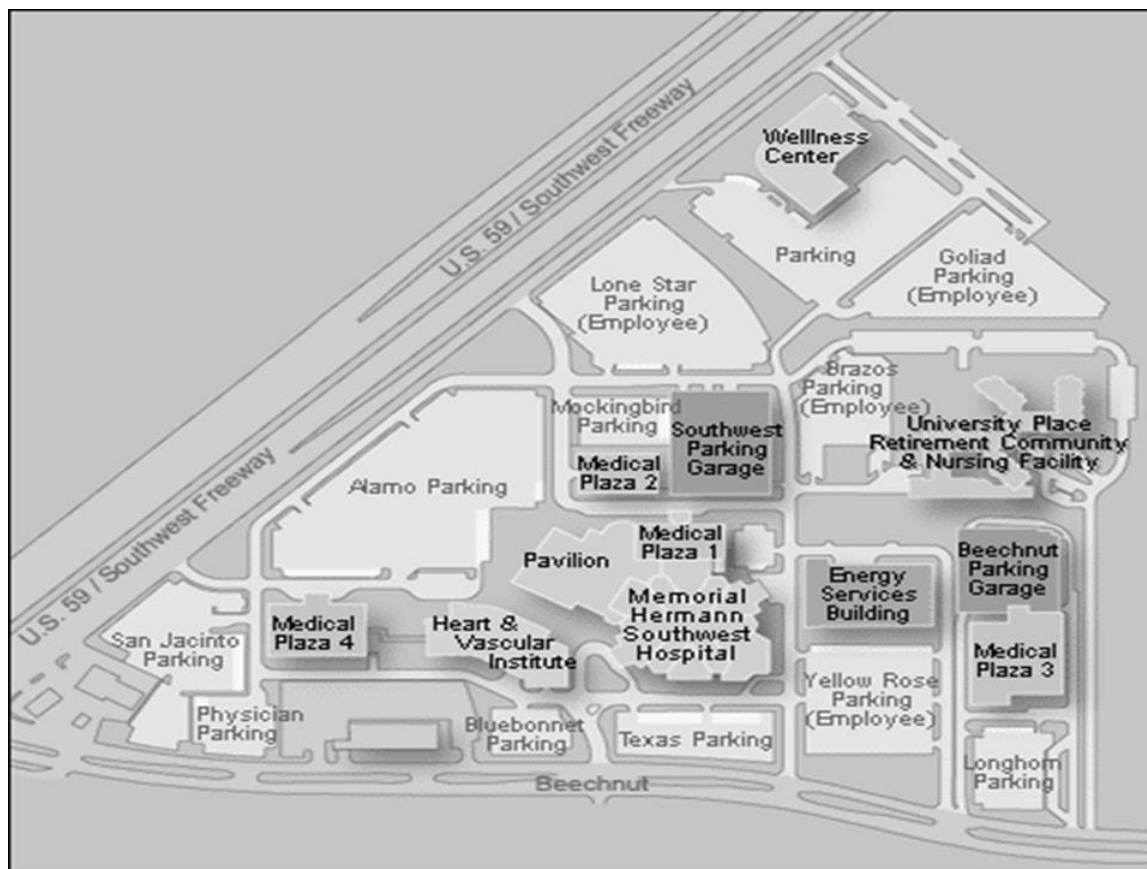
**Parking:** For easy access and your first visit to your office, we suggest you park in **GARAGE ONE** (covered parking garage attached to Medical Plaza 2 - 7737 SW Fwy). **Medical Plaza 1 - 7777 SW Fwy is directly across from GARAGE ONE.** Upon your arrival to CHEN SKIN AND CANCER SURGERY, P.A., sign-in and inquire about **Parking Validation.**

**Maps:** Located at the Memorial Hermann Southwest Hospital campus, CHEN SKIN AND CANCER SURGERY, P.A. is directly adjacent to the hospital building. Directions to the medical campus are listed below:

- **From US 59 N**, travel South. Exit Gessner/ Beechnut and go left under 59 and another left on to US 59 N feeder road (or make a U-turn). Turn right at the 2nd driveway to the right onto the Southwest Hospital Campus.
- **From Beltway 8**, exit 59 North. Exit Gessner/ Beechnut. Continue on US 59 N feeder road, past Beechnut. Turn right at the 2nd driveway to the right onto the Southwest Hospital Campus.
- **From IH 10 W**, travel east to US 59, then South on 59. Exit Gessner/ Beechnut and go left under 59 and another left on to US 59 N feeder road (or make a U-turn). Turn right at the 2nd driveway to the right onto the Southwest Hospital Campus.
- **From IH 10 E**, travel west to US 59, then South on 59. Exit Gessner/ Beechnut and go left under 59 and another left on to US 59 N feeder road (or make a U-turn). Turn right at the 2nd driveway to the right onto the Southwest Hospital Campus.

### Bring the following to your appointment:

- 1) Your driver's license, insurance card, and credit card or debit card. The payment card will be put on file for "no show" and cancellation fee and any other charges assigned to your account, such as the balance determined by your insurer as your share of the expenses. You will always be notified before any charges are necessary for your account. You can pay either with a check or the payment card we have on file for you. Our office accepts Visa, MasterCard, and Discover (no American Express).



**Dr. T. Minsue Chen**

7777 Southwest Fwy  
Medical Plaza 1 – Ste 748  
Houston, TX 77074  
(832)356-3872

- 1** US59 / Southwest Fwy
- 2** Beechnut St
- 3** Parking lot
- 4** Garage 1 Parking
- 5** Medical Plaza 1 (across the street from Garage 1)

- 2) After printing the **NEW PATIENT forms**, please complete and bring the forms with you to your appointment. Before you arrive for your appointment, we can review our Notice of Privacy Practices and Notice of Services Agreement on our website ([www.drminsuechen.com](http://www.drminsuechen.com)).
- 3) If you have a summary of your Health History, please bring it along. Specifically, Dr. Chen needs a list of your allergies, current medications, medical problems, and prior procedures. Additionally, if you have seen a doctor for your skin problem, it can sometimes be helpful to bring a copy of your medical records for Dr. Chen to review.

**What to expect from your appointment with us:** Dr. Chen and her staff will review your Health History. This will be followed by examination of your skin concerns and discussion of treatment options, which may or may not include a procedure. Please remember that if you have medical insurance, you are responsible for your co-payment/co-insurance/deductible at the time of service. Additionally, office procedures may be performed on the same day only if the procedure has been pre-approved/pre-certified by your insurance company. Kindly contact your insurance company to see if pre-authorization is necessary.

**Contacting our office:** Please do not hesitate to let us know if you have any questions. We are a small practice; therefore, if we do not answer the phone, it is because we are either caring for a patient who is in the office or on the phone with another patient. **We have found that the fastest and most patient preferred method of communication is via TEXT messaging. Therefore, kindly send us a TEXT message to our office number (832)356-3872, and we will reply as soon as possible.** Other methods to contact us include: 1) Send a "HELLO" from our website. 2) Email ([info@drminsuechen.com](mailto:info@drminsuechen.com)). 3) Leave a detailed message on our voicemail (832)356-3872. 4) Send a Fax (888)381-4541. All messages should be responded to by the end of the next business day. Please contact us again if you do not hear from us by the end of the next business day.

**Payment and collections policy:** In order to keep this office open and staff paid, we need our patients to take financial responsibility for their accounts and pay their bills in a timely manner. Payment is due at the time of service, and any outstanding balance is to be paid in full before any additional services and/or items are provided by Chen Skin and Cancer Surgery, P.A. The cost of any date of service is not complete until the finished documentation of that visit is reviewed for accuracy and completion and you may be sent an additional statement. Some treatments require several visits to treat and each is billed separately. Cosmetic procedures are to be paid in full at the time of service and will not be billed to your insurance carrier. Chen Skin and Cancer Surgery, P.A. reserves the right to assign additional fees to your account in the following instances: compensation for extra administrative expenses incurred, any check returned for nonpayment, form completion fee, declined charge on credit card, and medical records fee.

**Our promise to you:** Please review "OUR PROMISE TO YOU" webpage (SEE <https://www.drminsuechen.com/fees--charges.html>) regarding office policies and fee structure regarding: Timeliness; Payment Policies (\$20 late fees; \$50 returned check fee); Cancellation Policy (\$150 to \$500 fee depending on your reserved appointment type); Grounds for Termination of Patient-Physician Relationship; "No Jerk Rule", and availability and fee schedule for Virtual Visits and Appointments outside of regular hours. See also our Notice of Privacy Practices (<https://www.drminsuechen.com/notice-of-privacy-practices.html>) and Notices of Service Agreement (<https://www.drminsuechen.com/notice-of-services-agreement.html>).



**We look forward to caring for your skin health needs!  
Have a blessed day!**

Dr. Chen and staff

Date: \_\_\_\_\_ **THANK YOU FOR COMPLETING THESE IMPORTANT FORMS** ☺

1) Whom can we thank for referring you to our medical practice? \_\_\_\_\_

## 2) PATIENT DEMOGRAPHICS

Patient Name (LEGAL): Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Nick Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender (circle): M F

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Preferred Language (circle): English Spanish Other

Status (circle): Minor Single Married Divorced Widowed Separated Domestic Partner

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number (required for some insurance): \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Federal agencies require us to collect his following information regarding race and ethnic group:*

Race (circle): White Black American Indian Native Hawaiian/Pacific Islander Other PATIENT REFUSED

Ethnic Group (circle): Not Hispanic or Latino Hispanic or Latino Other PATIENT REFUSED

Advanced Directives: I, the patient, have an Advance Directive: YES NO If yes, please provide us with a copy.

## 3) WHO IS THE RESPONSIBLE PARTY OR GUARDIAN (if different from the patient)?

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## 4) WHICH IS YOUR PREFERRED PHARMACY?

Preferred Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Nearest Major Intersection: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## 5) IN CASE OF EMERGENCY, PLEASE CONTACT:

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Mother's maiden name \_\_\_\_\_ (for security use only)

**6) Authorization for Treatment:** I authorize the health care providers at Chen Skin and Cancer Surgery to perform medical and/or surgical procedures on me or the minor I am responsible for as she deems necessary for the treatment of skin conditions.

**X** Signature of Patient / Responsible party / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**SKIN HISTORY**

- When was your last SKIN SCREENING? \_\_\_\_\_
- What sunscreen do you use? \_\_\_\_\_ What SPF? \_\_\_\_\_
- When is your PROCEDURE with Dr. Chen SCHEDULED? \_\_\_\_\_
- In your lifetime, how many SKIN CANCERS have you had? \_\_\_\_\_ None
- In your lifetime, how many skin lesions have you had CUT OFF? \_\_\_\_\_ None
- In your lifetime, how many times have you had MOHS SURGERY? \_\_\_\_\_ None

**GENERAL HISTORY**

- Occupation: \_\_\_\_\_
- Exercise / Activity: \_\_\_\_\_ / week
- Pets: \_\_\_\_\_
- Smoking / Tobacco: \_\_\_\_\_ packs/ day
- Hobbies: \_\_\_\_\_
- Alcohol: \_\_\_\_\_ drinks/ day
- Upcoming activities (ie. social, travel, athletic, etc): \_\_\_\_\_

**MEDICAL / SURGICAL HISTORY**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

- Allergies to medications: \_\_\_\_\_
- Medications: \_\_\_\_\_
- Vitamins / Supplements: \_\_\_\_\_
- Medical problems: \_\_\_\_\_
- Surgeries in the past: \_\_\_\_\_
- Family history of medical problems, cancer, etc: \_\_\_\_\_
- Your Health Care Team / Doctors: \_\_\_\_\_

**YOUR VISIT WITH US**

- What is the reason for visit? \_\_\_\_\_
- Where is the problem located? \_\_\_\_\_
- How long has it been a problem? \_\_\_\_\_
- List the treatments so far: \_\_\_\_\_
- List the lab studies so far: \_\_\_\_\_
- Do you know anyone with a similar skin problem? \_\_\_\_\_
- What do you think is going on? \_\_\_\_\_
- What else do we need to know? \_\_\_\_\_



Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This often does not have anything to do with why you are here, but insurance requires that this paperwork be in your chart. Please circle those symptoms that apply to you at this time. If none of the symptoms apply to you, please check the area that says "I have none of the above".

**REVIEW OF SYSTEMS (circle what you have now)**

- Constitutional: Fever      Weight loss    Night sweats    Fatigue
- Skin: Rashes    Itching    Hair change    Nail change
- Eyes:      Loss of vision    Distorted vision    Eye pain
- ENT: Loss of hearing    Ringing    Dizziness    Nosebleeds    Hoarseness
- Cardiovascular: Chest Pain    Palpitations    Swelling of legs
- Pulmonary: Cough      Shortness of breath    Wheezing
- Endocrine: Heat or cold intolerance      Excessive thirst or hunger
- Gastrointestinal: Swallowing difficulty    Heartburn    Diarrhea    Vomiting
- Genitourinary: Urinary frequency    Blood in urine    Urinary pain
- Musculoskeletal: Joint pain    Muscle pain/ cramps
- Neurological: Headaches    Numbness/tingling    Weakness    Blackouts    Slurred speech
- Psychiatric: Anxiety    Depression    Mania
- Hematological: Easy bruising/ bleeding    Anemia
- Immunological: Frequent infections    Swollen lymph glands

( ) I have none of the above.

\*\*\*\*\* ALERTS: For your SAFETY, we review these alerts at EVERY visit. \*\*\*\*\*

**CHECK ALL THAT APPLY     None of the issues below**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Problems with healing (ie. slow heal, thick scars, keloid scars) | <input type="checkbox"/> PRE-procedure antibiotics recommended by your doctor | <input type="checkbox"/> Cancer in the past  |
| <input type="checkbox"/> Cosmetic / Plastic surgery                                       | <input type="checkbox"/> Artificial heart valve                               | <input type="checkbox"/> Radiation exposure (ie. acne, cancer, work-related)               |
| <input type="checkbox"/> Pregnancy / Planning pregnancy                                   | <input type="checkbox"/> VP shunt   | <input type="checkbox"/> Organ transplant  |
| <input type="checkbox"/> Breast feeding   | <input type="checkbox"/> Artificial joint in past 2 years                     | <input type="checkbox"/> Diabetes (last HgbA1c ____)                                       |
| <input type="checkbox"/> Active Infection   | <input type="checkbox"/> White coat syndrome                                  | <input type="checkbox"/> Kidney problems (Cr ____)   |
| <input type="checkbox"/> Frequent infection   | <input type="checkbox"/> Seizures   | <input type="checkbox"/> Other NOTABLE ISSUES that the surgical team needs to be aware of? |
| <input type="checkbox"/> MRSA/ Staph infection  | <input type="checkbox"/> Fainting / Passing out                               | _____  |
| <input type="checkbox"/> Pacemaker / Defibrillator  | <input type="checkbox"/> Allergy to Latex                                     | _____  |
| <input type="checkbox"/> Blood thinners   | <input type="checkbox"/> Allergy to Lidocaine                                 |  |
| <input type="checkbox"/> Bleeding problems  | <input type="checkbox"/> Allergy to Adhesive                                  |  |
|   | <input type="checkbox"/> Allergy to Topical Antibiotic                        |  |
| <input type="checkbox"/> Hepatitis B / Hepatitis C  | <input type="checkbox"/> Rapid heart with local numbing                       |  |
| <input type="checkbox"/> HIV / AIDS   | <input type="checkbox"/> Problems with anesthesia                             |  |

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HOW AND WHO CAN WE CONTACT ABOUT YOUR CARE AND RESULTS?**

**1. I PREFER TO BE CONTACTED IN THIS ORDER:**

<b>1<sup>st</sup></b> (first) preferred method to be contacted is by (CIRCLE one):	<i>Cell phone</i>	<i>Email</i>	<i>Home phone</i>	<i>Work phone</i>	<i>Another person</i>	<i>Not applicable</i>
<b>2<sup>nd</sup></b> (second) preferred method to be contacted is by (CIRCLE one):	<i>Cell phone</i>	<i>Email</i>	<i>Home phone</i>	<i>Work phone</i>	<i>Another person</i>	<i>Not applicable</i>
<b>3<sup>rd</sup></b> (third) preferred method to be contacted is by (CIRCLE one):	<i>Cell phone</i>	<i>Email</i>	<i>Home phone</i>	<i>Work phone</i>	<i>Another person</i>	<i>Not applicable</i>
<b>4<sup>th</sup></b> (fourth) preferred method to be contacted is by (CIRCLE one):	<i>Cell phone</i>	<i>Email</i>	<i>Home phone</i>	<i>Work phone</i>	<i>Another person</i>	<i>Not applicable</i>
<b>5<sup>th</sup></b> (fifth) preferred method to be contacted is by (CIRCLE one):	<i>Cell phone</i>	<i>Email</i>	<i>Home phone</i>	<i>Work phone</i>	<i>Another person</i>	<i>Not applicable</i>

**2. IF WE ARE UNABLE TO SPEAK WITH YOU, I WOULD LIKE THE OFFICE TO DO THE FOLLOWING:**

<b>a)</b> When calling my <b>CELL PHONE</b> (circle one):	<i>Okay to leave full details</i>	<i>Only leave call back number</i>	<i>Not applicable</i>
<b>b)</b> When sending a <b>TEXT MESSAGE</b> (circle one):	<i>Okay to leave full details</i>	<i>Only leave call back number</i>	<i>Not applicable</i>
<b>c)</b> When sending an <b>EMAIL message</b> (circle one):	<i>Okay to leave full details</i>	<i>Only leave call back number</i>	<i>Not applicable</i>
<b>d)</b> When calling my <b>HOME PHONE</b> (circle one):	<i>Okay to leave full details</i>	<i>Only leave call back number</i>	<i>Not applicable</i>
<b>e)</b> When calling my <b>WORK PHONE</b> (circle one):	<i>Okay to leave full details</i>	<i>Only leave call back number</i>	<i>Not applicable</i>
<b>f)</b> I hereby give my consent that <b>ANOTHER PERSON</b> may be contacted about my health information in non-emergency situations. I understand that I <b>MUST</b> provide their names, relationship, & contact information below (circle one): ***	<i>Okay to leave full details with my Emergency Contact (if other, list below)</i>	<i>Only leave call back number</i>	<i>Not applicable</i>

\*\*\*Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**X** Signature of Patient / Responsible party / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_