PATIENT REGISTRATION FORM 病人基本資料表

To help us provide you with the best possible care, please fill out this form as accurately as possible. All the information will be kept confidential.

Name (Last, First, Middle)姓名: SSN 社安號(optional):

Date of Birth 生日: ／ ／ Gender 性別: ☐ Male 男 ☐ Female 女 Marriage 婚姻: ☐ Married 已婚 ☐ Single 未婚

Address 住址:

City 城市: State 州: Zip Code 區域號:

Home phone 住家電話: ( ) Cell phone 手機電話: ( )

Email 電郵信箱: Employer 公司: Occupation 職業:

Emergency Contact 連絡人: Phone # 電話:

Primary Care Physician 家醫(optional): PCP phone # 家醫電話(optional):

Insurance Company 保險公司: Subscriber Name 保險人:

Subscriber Date of Birth 保險人生日: ／ ／ Policy / ID# 保險人號碼: Group #:

Relationship to the patient 病人是保險人的？: ☐ Self 保險人本身 ☐ Spouse 配偶 ☐ Children 小孩 ☐Other

2nd Health Plan 第二保險公司: Subscriber Name 保險人:

Subscriber Date of Birth 保險人生日: ／ ／ Policy / ID# 保險人號碼: Group #:

Relationship to the patient 病人是保險人的？: ☐ Self 保險人本身 ☐ Spouse 配偶 ☐ Children 小孩 ☐Other

Are you willing to receive promotions and news letter from us? 是否願意收到診所的電子信以及活動通知? ☐ Yes ☐ No

How do you know about us 從何處得知本診所：_____

Please describe your current health problem(s) 來診原因： _____

How and when it began 問題是何時及如何開始： _____

How often are your symptoms present? 症狀發作的頻率： ☐Constantly ☐Frequently ☐Intermittently ☐Occasionally

Can you perform your daily activity? 是否影響日常作息： ☐Yes, all activities ☐Some activities ☐Not at all

Are you currently under the care of a physician? 有看其他醫生嗎：☐No ☐Yes, doctor's name: _____

What treatment have you been taking for above condition(s) 正在接受的其他治療：

☐ Medications ☐ Injections ☐ Physical Therapy ☐ Chiropractic _____

Surgeries 手術：When ____／____Why _____

When ____／____Why _____

Are you using any prescriptions or herbal medicines? 目前正在服用的藥物：_____

_____

Medical Devices 正在使用的醫療儀器 : ☐ Pace Maker 起搏器 ☐ Internal Hardware 體內儀器 ☐ Others _____

Allergies 已知會導致過敏物質:

☐ Foods _____

☐ Environment _____ ☐ Medications _____

_____

I certify the above information is complete and accurate to the best of my knowledge. I agree o notify this provider immediately whenever I have changes in my health condition.

Patient Signature: _____ Date:_____

Or Patient Representative Indicate relationship if signing for Patient _____