首次问诊病人信息采集表

Date:

New Patient Intake Form

**病人资料/ Patient Information**

英文姓氏/Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_ 英文名字/First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial:\_\_\_\_

出生日期/Date of Birth(MM/DD/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 性别/Gender:[ ] 男Male [ ] 女Female [ ] Other

工卡号/Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 种族/Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

住址/Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_邮编/Zip code:\_\_\_\_\_\_\_\_\_

常用语言/Language: [ ] English [ ]  普通话Chinese– Mandarin [ ]  广东话Chinese—Cantonese

[ ]  福州话Chinese—Fuzhounese [ ] 台山话Chinese—Toishanese [ ] Spanish [ ] Korean [ ] Other:\_\_\_\_\_\_\_

婚姻状态/Marital Status: [ ] 单身Single (Unmarried, divorced and widowed) [ ] 已婚Married [ ] Other

手机号码/Mobile Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 住家电话/Home Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

邮箱/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_常用联系方式/ Preferred method: [ ] Mobile [ ] Home [ ] Email

药房名称/Pharmacy: (或向前台出示您的药房名片) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

药房电话/Pharmacy phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

职业状况/Employment: [ ] 退休Retired [ ] 自雇 Self- employed [ ] 受雇 Employed [ ] 其他 Other:\_\_\_\_\_\_

紧急联系人/Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 关系/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

住址/Address: (If different from your home address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

电话/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_邮箱/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

转介信医生/Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_家庭医生/PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**保险资料/ Insurance Information**

**请向前台出示您的医疗保险卡以供记录/ Please present your insurance cards to front desk for record**

**家长或监护人资料（十八岁以下病人必需填写）/ Parent or Guardian Information (For Patient Age Under 18）**

监护人姓名/Guardian: (Last Name/姓)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(First Name/名)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

关系/Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_手机号码/Mobile Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

邮箱/Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**同意书 /Consent**

**医疗资料保密通知/Acknowledgement of HIPAA notice privacy practices**

为遵守健康保健流通和职责法案规定，此医务所之人员已公布并或提供了一份医疗保密通知书的内容，本人在此认同并声明，我已审阅或已取得此通知的复印本。

I hereby acknowledge that I have fully reviewed and/ or have received a complete copy of the HIPAA notice of privacy practices provided by the staff of this office.

**Consent to Photograph**

本人允许百康心理健康专科属下之医生与员工拍摄我的照片与复印一切有关文件(包括保险卡与病例等)。本人明白以上所述全属机密医疗记录的一部分，而照片将会用于治疗或内部培训之用。本医务所将不会使用或对任何人发放未经本人书面同意的资料。

I give my permission for Excelsior Mental Health Care to obtain photographs of me, my insurance cards, and other documents deemed necessary. I understand that the photographs taken of me are part of my confidential medical record, may be used for treatment and educational purposes, and will not be used or released to any other party without my writer authorization. I understand that I can revoke this permission at any time by submitting my request in writing.

**Medicare/ Medicaid Assignment of Benefits**

病人在此声明，以上本人所提供之所有病人登记资料是正确的。我授权此医务所向政府福利机构索取此医务所应得的服务费用。

I certify that the information given by me in applying for payment is correct. I authorize the release of all records of request. I request that payment of authorized benefits be made on my behalf.

**Assignment of Insurance Benefit**

我同意由我受保的保险公司直接支付百康心理健康专科所提供服务的医疗费用。如果我的医疗保险无效时，我愿意负责结清所有诊金和治疗费用。

I hereby authorize direct payment of medical benefits to Excelsior Mental Health Cares for services rendered by all medical providers in the corporation. I understand that I am financially responsible for any balance if my insurance is invalid.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

病人/监护人姓名(正楷) Patient/ Guardians Name (Please print) 与病人关系/ Relationship

签名/ Signature 日期/ Date (MM/DD/YYYY)

A photocopy of these assignment shall be valid as the original. 此份文件的复印本与原件一样并足以证明我的委托与认同声明。(12/2021)