**Patient Registration Form (就医注册及社会和经济状况调查表)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **病人 (Patient):** |  |  |  |  |  |  | **性别 (Sex):** |  |
|  | **姓 (LastName)** |  | **名 (First Name)** |  | **Middle Initial** |  | **男 (M)** | **女 (F)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **出生日期(Date of Birth):** |  | **年龄(Age):** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **家庭地址 (Address):** | |  | | |
|  | | 街道 (Street) 城市 (City) 州 (State) 邮政编码 (Zip Code) | | |
| **职业 (Occupation):** |  | | **雇主 (Employer):** |  |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **婚否 (Marital Status):** |  | **社会安全号**  **(SSN):** |  |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **住宅电话**  **(Home Phone):** |  | **手机**  **(Cell):** |  | **电子邮件**  **(Email):** |  |

**有否医疗保险 (Do you Have Medical Insurance?)**: Please check \*

没有 (No) 有 (Yes) ­­­­

|  |  |
| --- | --- |
| 保险公司名称 (Insurance Company): |  |
| 医疗保险号码 (ID # and group #): |  |

**有否有家庭医生 (Primary Care Physician)**: Please check\* 没有 (No)  (Yes)

|  |  |
| --- | --- |
| **家庭医生姓名和电话** ( Primary Care Physician): |  |

**­­­­­­­­­­紧急联系人信息 (Emergency Contact Information)**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **姓名(Name):** |  | **与患者关系 (Relationship):** |  | **电话 (Phone):** |  |

|  |  |
| --- | --- |
| **所住家庭人数** (Number Residents): |  |
| **与住户关系** (Relationship with Residents): | |  | **住户电话 (Phone):** |  |

**居住类型 (Type of Residence)**: Please check\*

独立屋 (Single Home) 连栋屋 (Town Home) 公寓 (Condo)

老年公寓 (Senior Apartment) 收容所 (Shelter) 其他 (Other)

**家庭年收入水平 (Income Level per Year)**: Please check\*

>$5,000 >$10,000 >$15,000 >$20,000 >$25,000

**收入来源 (Income Sources): Please check\***

工资 (Wages) 退休金 (Pension) 社会保险福利 (SSB)

**教育程度 (Education Level): Please check\***

初中 (Intermediate School) 高中 (High School) 大学肄业 (College Study)

大学学士 (BA/BS Degree) 硕士学位 (MA/MS Degree) 博士学位 (PHD Degree)

**移民美国年数 (Years of Immigration): Please check\***

>5年 >10年 >15年 >20年

**移民身份 (Legal Status): Please check\***

公民 (Citizen) 永久居民 (Permanent Resident) 其他 (Other)

我, ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 保证上述信息是真实准确的。如果我的健康状况发生变化和/或上述任何信息需要更改时，我会及时通知该诊所。 我理解并同意对所提供的医疗服务而产生的费用负全部责任。

（I ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes in my health status and/or information listed above. I understand and agree that I am ultimately responsible for the payment for any professional services rendered.)

|  |
| --- |
|  |
| 申请人签字 (Authorized Signature of Subscriber) | | 日期 （Date） |