**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** |  | [x] **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):** |  |   |

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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） |