Bellevue Health Clinic

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Patient Registration Form (病人登记表)

Please fill out form completely. (请以正楷填写)

Last Name(姓): _____M.I._____First Name（名）:_____

Date of Birth（出生日期）:月_____/日_____/年_____ Sex (性别): ❑ Male（男） ❑ Female (女)

Marital Status(婚姻状况) ❑ Single :(单身) ❑ Married (已婚) ❑ Divorced (离婚) ❑ Widowed (丧偶) ❑ Separated (分居)

Address(地址):_____Apt#(单元):_____

City(市)_____ State(州)_____ Zip(邮编): _____Email(邮件):_____

Home Phone(电话): _____ Cell Phone(手机): _____

Employer(雇主):_____ Phone(单位电话): _____

Employment Status 工作状况: [ ] Full time 全职 [ ] Part time 兼职 [ ] Unemployed 无业 [ ] Retired 退休 [ ] Student 学生 [ ] Other:

Language(语言): □English 英语 □Mandarin 普通话 □ Cantonese 广东话 □Other

Previous PCP(曾经的家庭医生): Phone(电话):

Emergency Contact(紧急联系人): ❑ I authorize Bellevue Health Clinic to release health information to my Emergency Contact/s. 同意授权

Name(姓名): _____Relationship(关系): _____Phone(电话) _____

Name(姓名): _____Relationship(关系): _____ Phone(电话)_____

Insurance Information 保险信息 ❑Self pay 自费

Primary Insurance(保险): _____Relation to Subscriber(关系): ❑Child ❑Spouse ❑Other_____

ID #: _____Group #: _____

Subscriber Name(姓名): _____ Birth Date(生日): _____ Phone #: _____-_____-_____

Secondary Insurance(保险): _____ Relation to Subscriber(关系): ❑Child ❑Spouse ❑Other_____

ID #: _____Group #: _____

Subscriber Name(姓名): _____ Birth Date(生日): _____ Phone #: _____-_____-_____

ACKNOLDGEMENT OF REVIEW NOTICE OF PRIVACY PRACTICES （隐私权公告）

X: _____Date(日期): _____

Patient/Guardian Signature 患者，监护人或个人代表签字

ASSIGNMENT AND RELEASE （财政协议）

I hereby authorize my insurance benefits be paid directly to Bellevue Health Clinic. I also authorize the release of any and all information required in the processing of the claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees. I am financially responsible for non-covered services. 我同意由我的保险公司向 惠爱诊所 直接支付诊金及服务费用. 我亦授权披露我所有的医疗资料以便能确定应得的保险款项。如保险公司不支付或未能付足医疗费用, 本人将负责付清.

X: _____ Date(日期): _____

Patient/Guarantor Signature 患者，监护人或个人代表签字

Bellevue Health Clinic 惠爱诊所 Date 日期: _____

PATIENT MEDICAL HISTORY 病史

Last Name 姓 **First Name 名** **Middle (INITIAL)**

Preferred Pharmacy 药房: ☐ **N/A**

Allergies

❑ No Known Allergies 无过敏

❑ Sulfa Drugs 磺胺 ❑ Adhesive Tape 胶带 ❑ Wheat 小麦 ❑ Aspirin 阿司匹林 ❑ Codeine 可待因

❑ Dairy Products 奶制品 ❑ Iodine/Shellfish/Dye 造影剂 ❑ Latex 乳胶 ❑ Penicillin 青霉素 ❑ Peanut 花生

OTHER:

FAMILY HISTORY 家族史 – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	**FATHER**	**SIBLING (Brother/Sister)**
Cancer, type 肿瘤			
COPD 慢阻肺			
Diabetes 糖尿病			
Heart attack/CAD/CHF 心脏病			
Hypertension 高血压			
Kidney disease 肾脏病			
Stroke 中风			

SOCIAL HISTORY

Occupation 职业: _____ ☐ Disabled 残障 (reason _____)

☐**Yes** ☐**No -** Do you drink alcohol 酒? (____ drinks) ☐ Daily ☐Weekly or ☐Socially, ☐ Beer ☐ Wine ☐ Liquor _____

☐**Yes** ☐**No -** Do you use tobacco 烟? ☐ Smoke (____ packs/Cigarettes per day) (_____ years) ☐ Vapor ☐ Marijuana

☐**Yes** ☐**No -** Do you use any drugs 毒品? Type of drug _____

Surgical History 手术史: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY 手术	**YEAR or DATE 日期**	**DOCTOR 医生**	**LOCATION 地点**

Medical History: Have you ever had any of the following?

❑ NONE 无

❑ ADD/ADHD 多动症 ❑ CAD/Heart Attack 心脏病 ❑ hyperlipidemia 高血脂 ❑ Migraines/headaches 偏头痛

❑ Alzheimer's Disease/Dementia 痴呆 ❑ CHF/congestive heart failure 心衰 ❑ hypertension 高血压 ❑ Osteoporosis 骨质疏松

❑ Anemia 贫血 ❑ COPD / Asthma 慢阻肺/哮喘 ❑ hyperthyroidism 甲亢 ❑ Pulmonary embolism/Blood clot 血栓

❑ Anxiety/Depression 焦虑/抑郁 ❑ Crohn's disease 克隆氏症 ❑ hypothyroidism 甲低 ❑ Seizure disorders 癫痫

❑ Arthritis 关节炎 ❑ Diabetes Type1 or 2 糖尿病 ❑ irritable bowel syndrome ❑ Sleep Apnea 呼吸睡眠综合征

❑ Atrial fibrillation/Flutter 房颤 ❑ Fibromyalgia 纤维肌痛 ❑ kidney problems 肾病 ❑ Stroke/TIA 中风

❑ BPH 前列腺肥大 ❑ GERD/Acid Reflux 胃酸反流 ❑ Liver disease/hepatitis 肝炎 ❑ Cancer 肿瘤

❑ Chronic pain 疼痛 ❑ Gout 痛风 ❑ Lupus 红斑狼疮 ❑

For Females: Date of LMP 上次月经: _____ Number of Pregnancies 怀孕: _____

Date of Last Pap Smear 宫颈涂片: _____ Miscarriages 流产: _____ Living Children 孩子: _____

Date of Last Mammogram 乳房 X 光:_____ Method/s of Contraception 避孕方式: _____

Medications: List any medications you are currently taking (please include over the counter medications):

MEDICATION 药品	DOSAGE 剂量	Frequency 次数

Do you have a living will（你有遗嘱）? _____ If yes, please provide us a copy.如果有，请提供。