Manhattan Pediatric Associates, P.C.

Referred by/介紹人: _____ Date 日期: _____/_____/_____

Patient Information/病人資料 Newborn Screen: #_____

_____ _____ _____ _____

Last Name 姓(英文) First Name 名(英文) Middle Name Chinese Name 中文名

_____ _____ _____ _____ _____

Address 地址 City 城市 State 州 Zip 郵區 Home phone 電話

Date of birth/出生日期: _____/_____/_____ Gender/性別 : M/男 F/女 Patient's cell _____

Language/語言 : ☐ Cantonese/廣東 ☐ Mandarin/國語 ☐ English/英語 ☐ Others/其他_____

E-mail/電郵: _____ Social Security/工卡號碼: #_____

Patient/Guardian/父母或監護人

母親 出生 工卡 手提電話

Mother_____ DOB ____/____/_____ SS # _____ Cell phone_____

父親 出生 工卡 手提電話

Father_____ DOB ____/____/_____ SS # _____ Cell phone_____

Guardian/監護人

姓名 出生 與病人關係 手提電話

Name _____ DOB _____/_____/_____ Relationship_____ Cell Phone_____

如有緊急情況通知 電話 與病人關係

In Case of Emergency Notify_____ Phone_____ Relationship _____

Health Insurance Information/醫療保險資料 Medicaid/醫療卡 _____

第一保險公司名稱

Primary Insurance _____ PCP_____ Copay _____ Policy # _____

Subscriber's Name/ 購買人姓名 _____ Gender/性別: M/男 F/女

Subscribe's Social Security/購買人工卡號碼 # _____ Relationship/與病人關係 _____

第二保險公司名稱

Secondary Insurance _____ PCP_____ Copay _____ Policy # _____

Subscriber's Name/ 購買人姓名 _____ Gender/性別: M/男 F/女

Subscriber's Social Security/購買人工卡號碼 # _____ Relationship/與病人關係 _____

Medical Information/醫療資料

Past Major Illness or Surgery/過往病歷: _____

Allergies/敏感 _____ Chronic Medication/服食藥物 _____

I hereby acknowledge receipt of the notice of privacy practices. 我已收到醫療資料保密通知書及清楚瞭解其內容.

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN: I hereby authorize my Insurance Carrier to pay all fees DIRECTLY to: Manhattan Pediatric Associates, P.C. I understand that I shall be responsible for payment of services not covered by my insurance and that it is my responsibility to understand the full benefit and extent of the coverage of my insurance policy.

我授權予我的保險公司直接支付醫療費用給民鐵吾兒科中心, 並瞭解我將須要承擔一保險公司拒絕支付的費用.

Signature of self/parent 簽署(自己/父母) _____ Date/日期 _____

Signature of guardian 簽署(監護人) _____ Date/日期 _____