CITY OPHTHALMOLOGY

1740 South St. Suite 400
Philadelphia, PA 19146
Tel 267-607-6888 Fax 267-393-4310

PATIENT REGISTRATION FORM | 登记表

Last Name: First Name: Date of Birth:
姓_____ 名_____ 出生日期_____

Social Security No. Email Address
工卡/社会安全卡号_____ 电子邮箱_____

Address
地址_____

Gender: (please check one/请选项） Marital Status: (please check one/请选项）
性别: Male|男___ Female|女___ 婚姻状况: Single|单身___ Married|已婚___ Divorced|离婚___ Other|其他___

Home Phone Work Phone
家庭电话_____ 工作电_____

Cell Phone Accept Text Messages?
手提电话_____ 接收短信吗? ___Yes |收 ___No | 不收

Emergency Contact Name / Phone / Relationship:
紧急联系人姓名 / 电话/ 与病人的关系_____

Primary Care Doctor Name / Phone /Address:
家庭医生名字 / 电话 / 地址_____

Referring Doctor Name / Phone / Address:
推荐医生名字 / 电话 / 地址_____

Prefer Pharmacy Name / Phone / Address:
常用药房名字 / 电话 / 地址_____

Financially Responsible party (if different from patient) / 债务责任方(如不是病人本人）

Full Name DOB Gender
姓名_____ 出生日期_____ 性别_____

Relationship to patient Address
与病人的关系_____ 地址_____

Consent for receiving Text messages and Emails / 接收短信或电子邮件许可

I gave permission to City Ophthalmology to contact me using Text messages with my Cell Phone no. and Email address listed above.
我接受 City Ophthalmology (城市眼科)用以短信或电邮模式联系我。
By providing your email address, you will receive instructions on how to access your medical records through our online patient portal.
通过您提供的电子邮箱，您将收到关于如何能上网提取您在我们诊所的医疗档案记录。 **Initial _____**

Insurance Acknowledgement / 医疗保险

I understand that it is my responsibility to notify City Ophthalmology (Lam Oculofacial Plastic Surgery PLLC) of any changes to my insurance. Failure to do so may reflect a balance on my account with City Ophthalmology (Lam Oculofacial Plastic Surgery PLLC).
我明白我有责任告知城市眼科有关我的医疗保险内容与改动,否则会收到有关账单并承担相关费用。 **Initial _____**

Privacy Notice / 私隐条例

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARATION: I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE and/or other insurance provider(s) for services rendered. I understand and agree to the above conditions.
我明白并同意授权城市眼科使用我的医疗信息向保险公司索取有关医疗费用。
HIPAA PRIVACY RIGHTS AND AUTHORIZATION FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION: I have read the HIPAA rights and authorization statements and give my consent for disclosure of my medical records related to treatment.
我已阅读及明白《私隐保密程序通知》,并同意医生根据我病况治疗需求公布我的健康资信。

_____ _____ _____
Patient Signature 患者签名 Guardian Signature 监护 人签名 Date 日期