PATIENT REGISTRATION FORM
病人註冊表格

NAME _____ 中文姓名_____

ADDRESS 地址 _____

CITY 城市 _____ STATE 州 _____ ZIP 郵號_____

TELEPHONE 電話 (_____)

SINGLE 單身	□	INSURANCE COMPANY 保險公司
MARRIED 已婚	□	
DIVORCED 離婚	□	POLICY NO: 保險單號號
WIDOWED 鰥寡	□	
Male 男 □		INSURANCE ID: 保險單號碼:
Female 女: □ Other ___		
DATE OF BIRTH 出生日期:		

EMPLOYER 職業/僱主		SSN 社會安全號碼:	
BUSINESS ADDRESS 僱主地址	CITY 城市	STATE 州	ZIP 郵號
TELEPHONE (OFFICE) 電話			

SPOUSE/PARENT 配偶/父母 _____ REFERRED BY 介紹您來的 _____

MEDICAL HISTORY

1. What is your major complaint
   請述任何不適症狀? _____

	YES	NO
2. Are you under a physician care now 您現在正接受醫生的治療中嗎?	□	□
3. Have you ever have trouble with prolonged bleeding 您有過流血不止嗎?	□	□
4. Have you ever had any unusual reaction to any drug or local anesthetic 您對任何藥物或局部麻醉有過敏的現象嗎?	□	□
5. Are you taking any kind of medication at this time 您現在有否服用任何藥物?	□	□

6. Please circle any illness you have ever had 請圈出曾有過的疾病:

Allergies 過敏 Anemia 貧血 Asthma 哮喘 Aids 愛滋病 Diabetes 糖尿 Epilepsy 癲癇
Hepatitis 肝炎 Kidney 腎病 Rheumatic fever 風濕熱 Tuberculosis 肺結核
Heart Problem 心臟病 High Blood Pressure 高血壓 Other 其他:

7. Is there any other information about your health which should be known 有其他任何關於您健康的問題應該讓我們知道的嗎?	□	□
8. Are you pregnant now 您現是否懷孕?	□	□

SIGNATURE 簽名: _____

DATE 日期: _____