Acuiderm

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皮膚內外專科皮膚美容專科 Dermatology & Cosmetic Surgery

Patient Information 病人資料:

Last Name 姓: _____ First Name 名: _____

Marital Status 婚姻狀況: ☐ Married ☐ Single 未婚 ☐ Other 其他: _____

Social Security Number 工卡號碼: _____-_____-_____

Date of Birth 出生日期: _____/_____/_____ Gender 性別: ☐ Male 男 ☐ Female 女

首選語言 Language: ☐ Chinese 中文 ☐ English 英文 ☐ Spanish 西班牙語 ☐ Other 其他: _____

民族 Ethnic Group: ☐ Hispanic 西班牙裔/拉丁裔 ☐ Non-Hispanic 不是西班牙裔或拉丁裔

種族 Race: ☐ Asian 亞裔 ☐ Black 黑裔/非裔美國人 ☐ White/ Caucasian 白人

☐ Native American 美國本土印第安人 ☐ Other 其他族裔

Preferred Contact Method 首選通訊方式: ☐ Phone 電話 ☐ Mail 郵件 ☐ Portal 病人網站

Enable Portal 啟用病人網站: ☐ Yes/ ☐ No Email 郵件地址: _____

Emergency Contact Person Name 緊急聯絡人姓名: _____ Phone 電話: _____

Patient Phone 病人電話: Home 家 _____-_____-_____ Mobile 手機 _____-_____-_____

Address 地址: _____ City 城_____ State 州 _____ Zip 郵區_____

Employer Name 雇主: _____ Occupation 職業: _____

Insured Information 受保人資料 : Relationship 與病人關係: ☐ Child ☐ Spouse ☐ Other_____

Last Name 姓: _____ First Name 名: _____

Date of Birth 出生日期: _____ /_____/_____ Gender 性別: ☐ Male 男 ☐ Female 女

Same Billing Address 相同地址: ☐ Yes ☐ No Phone Number 電話: _____-_____-_____

Address 地址: _____ City 城_____ State 州 _____ Zip 郵區_____

Guarantor 監護人資料 (under 18 ONLY) 僅限 18 歲以下: Relationship 與病人關係: ☐ Child ☐ Other_____

Last Name 姓: _____ First Name 名: _____

Date of Birth 出生日期: _____ /_____/_____ Gender 性別: ☐ Male 男 ☐ Female 女

Pharmacy Name 藥房姓名: _____ **Phone 藥房電話:** _____-_____-_____

I understand and agree that (regardless of my insurance status), I am responsible for the balance on my account for any professional service rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized Medicare benefits and all other insurance carriers be made on my belief to JAMES JIAN CUI, MD PHD for services furnished to me by the provider. I authorize Dr. JAMES JIAN CUI to release my medical information to the Health Care Financing Administration and its agents and all other insurance carriers needed to determine benefits payable for related services. If the insurance check is mailed to me instead of the doctor, I will send the check in within one week or charged interest.

Patient / Parent Guardian (Print Name) 病人或監護人姓名: _____ Relationship 關係: _____

Signature 病人簽名或監護人簽名: X _____ Date 日期: _____/_____/_____