Dallas E&W OB/GYN Clinic Patient Registration 病人注册

PATIENT INFORMATION 病人资料

LEGAL NAME 正式用名_____ _____ **SS# 社会安全号**_____
Last name/姓 First name/名

PREFERRED NAME 喜欢用名_____ **AGE 年龄** _____ **BIRTHDAY 出生日期**_____

ADDRESS 家庭地址 _____ **APT #** _____ **CITY 城市**_____

State 省份_____ **ZIPCODE 邮编** _____ **HOME PHONE 家里电话**_____

CELL 手机号码_____ **WORK 工作电话**_____

BEST NUMBER TO CALL FOR RESULTS: 您认为那个电话是我们可以与您商讨化验结果的： _____

IF IT'S OK TO LEAVE A MESSAGE /TEXT MESSAGE :能否留言或发短信：YES 可以_____ **NO 不可以**_____

MARITAL STATUS 婚姻状态: Single 单身_____ **Married 已婚** _____ **Divorced 离婚** ____ **Widow 丧偶**_____ **other 其他**_____

REFERRED BY 是谁推荐你来的_____**PCP 家庭医生**_____**PHONE 电话**_____

PHARMACY 药房的名字_____ **PHONE 电话号码**_____

EMERGENCY CONTACT 紧急联系人姓名 _____ **RELATIONSHIP 关系**_____

PHONE 紧急联系人电话号码_____

PRIMARY INSURANCE HOLDER 医疗保险持卡人资料：

POLICY HOLDER NAME 持卡人姓名 _____ **SS# 社会安全号**_____

BIRTHDAY 出生日期_____ **RELATION 与病人关系 SELF 本人** _____ **SPOUSE 夫妇**_____**PARENT 父母** _____ **OTHER 其它**____

ADDRESS 地址 _____ **CITY 城市** _____ **STATE 省份**_____ **ZIP 邮编**_____
(IF DIFFERENT FROM PATIENT)（如和病人地址不同的话）

HOME PHONE 家庭电话_____ **CELL PHONE 手机号码**_____

SECONDARY INSURANCE (IF APPLICABLE)/第二份保险资料（如果有的话）

POLICY HOLDER NAME 持卡人姓名_____ **BIRTHDAY 出生日期**_____

HOME PHONE 家里电话_____ **CELL PHONE 手机号码**_____

I hereby assign all medical and /or surgical benefits, including major surgery benefits to which I am entitled - through private insurance or any other health plan- to Dallas E&W OB/GYN Clinic. I authorize the release of any medical information necessary to process insurance claims. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are covered by insurance. A photocopy of this assignment shall be considered as valid as the original. If payment has not been received from my insurance company within 60 days, I understand it is my responsibility to contact the insurance company and ensure timely payment. Any overpayment on my account will be promptly credited or refunded. I also understand that the quote provided from my insurance company does not guarantee payment. The actual payment amount will be determined once the explanation of benefits is received**. Consent to treatment:** I hereby authorize the physician to treat myself - or if a **minor**, my daughter - as deemed medically necessary.

PATIENT/LEGAL GUARDIAN SIGNATURE 签名 _____ **DATE 今天日期** _____

Medical History/疾病史

Name/您的姓名_____Age/年龄_____

(Check all that applies)(请在有的选项中打钩)

本人 Self	/家庭成员 Family		本人 Self	/家庭成员 Family	
( )	( )	Anemia/Blood Disease/贫血/血液病	( )	( )	Arthritis/Osteoporosis/关节炎/骨质疏松症
( )	( )	Hypertension/Stroke/高血压/中风	( )	( )	Blood Clots In Legs/腿部血栓
( )	( )	Heart Disease/心脏病	( )	( )	Uterine Fibroids/子宫肌瘤
( )	( )	High Cholesterol/高胆固醇	( )	( )	Endometriosis/子宫内膜异位症
( )	( )	Diabetes/糖尿病	( )	( )	Heavy or Irregular Periods/月经量过多或不规律
( )	( )	Depression/Anxiety/抑郁/焦虑	( )	( )	Breast Mass/Breast Pain/乳房肿块/乳房痛
( )	( )	Thyroid Disease/甲状腺疾病	( )	( )	Epilepsy/Neural Disease/癫痫/神经系统疾病
( )	( )	Asthma/Lung Disease/哮喘/呼吸道疾病	( )	( )	Urinary Incontinence/Infection/尿失禁/尿路感染
( )	( )	Hepatitis/Liver Disease/肝炎/肝脏疾病	( )	( )	Uterine Prolapse/子宫脱垂
( )	( )	Gall Bladder Disease/胆囊疾病	( )	( )	Cancer History/癌症史
( )	( )	Kidney Disease/肾脏疾病	( )	( )	Excessively Weight Gain/Loss/体重过度增加/降低
( )	( )	Bowel Problems/肠道功能紊乱	( )	( )	Sexually Transmitted Disease/性传播疾病

*** Height 您的身高 ：**_____ ***Usual Weight/您目前的体重**_____lbs.

List of Surgeries (if any) 以往手术史

Date/日期 **What type of surgery**/何种手术

_____ _____

_____ _____

_____ _____

Current Medications/日常用药

_____

_____

Medication Allergies (if any)/ 有无药物过敏

_____

_____

Do you consume alcohol?/您是否喝酒？___ NO ___ YES _____ times/week/每周多少次？

Do you smoke cigarettes?/您是否抽烟？___ NO ___YES _____pack/week/每周多少包？

Do you drink coffee?/您是否喝咖啡？ ___ NO ___YES _____cups/day/每天几杯？

Exercise Regularly?/您有做常规锻炼吗？ ___ NO ___ YES_____ times/week/每周多少次？

MENSTRUAL HISTORY:/您的月经史：

What age did you start your first period?/您几岁来第一次月经？_____
1st day of last menstrual period/哪天是您末次月经的第一天？_____
Length of flow/一共来了几天？_____
Days between periods/二次月经之间间隔多少天？_____Do you have cramps/您是否有痛经？( ) Yes ( ) No
Bleeding during menstruation 月经期出血量？( ) Light/较少( ) Medium/中量 ( ) Heavy/很多
Pre-Menstrual Dysphoric Disorder (PMS)经前期综合症 ( ) Yes ( ) No

Comments/有何评论？

PREGNANCIES /怀孕史

Gravida/总的怀孕次数 _____ Full Term/足月产次数_____ Preterm/早产次数_____
Miscarridges/自然流产次数_____ Abortion/人工流产次数_____Ectopic/宫外孕次数_____

Birth date 出生日期	Length of Pregnancy 怀孕的孕周周数	C/S or Vaginal 剖腹产/自然阴道产	Sex 性别	Birth Weight 婴儿出生体重
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Any Complications?/有无任何并发症？ **Please explain**/请详细解释

_____

_____

Answer Yes or No/答复是或否(***if Yes, please include latest date***)(如果是，请注明最后一次检查的日期)
Pap smear/子宫颈抹片检查 _____ ( ) Normal 正常 / ( ) Abnormal 不正常
Mammogram/乳房 X 光检查 _____
General health panel/常规血液检查_____Bone Density Test/骨质密度测试 _____
Pelvic sonogram: 盆腔超声波检查_____ Colonoscopy/直肠镜检查 _____
Current method of birth control/目前使用的避孕方法_____
Do you need any information about birth control? /你是否需要任何避孕的信息？ ( ) YES ( ) NO

IMMUNIZATION STATUS/免疫接种情况

Hepatitis A / 甲型肝炎:（ ）YES/已经免疫 （ ） NO/没有免疫 （ ） Not sure/不清楚
Hepatitis B/乙型肝炎:（ ）YES/已经免疫 （ ） NO/没有免疫 （ ） Not sure/不清楚
If yes, are you the chronic carrier? 如果是的话，你是否是乙肝病毒的携带者？ _____
HPV Vaccine/人乳头状杆菌病毒疫苗：（ ） YES/已经接种 （ ） NO/没有接种 （ ）Not sure/不清楚

Reason for your visit? /请问您今天来看医生的原因是什么呢？

WENLIANG SHI, MD, PHD
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Confidentiality
Authorization for Use and Disclosure of Health Information

I acknowledge that a copy of Dallas E & W OB/GYN Clinic's HIPAA Notice of Privacy Practices is available to me, which explains how my medical information will be used and disclosed.

Other Uses and Disclosures: Disclosure of your health information for any purpose other than what is listed in the "Notice of Privacy Practices" it will require your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke will not affect or undo any disclosure made before your revocation date. You have the right to request restrictions on the use and disclosure of your health information.

Note: If I have provided e-mail addresses for my Preferred Contacts, my signature below indicates that I understand and acknowledge that e-mail communication is not secure. E-mail can be intercepted during transmission. Unencrypted messages (and any attachments) can be read and potentially copied and forwarded by others. E-mails can be easily viewed by someone other than the intended recipient if, for example, I access messages via a smartphone or tablet.

➔ _____

Print Patient Name **Date of Birth**

➔ _____

Signature of Patient **Date**

_____

Patient Representative /Legal Guardian **Relationship to Patient**

E-Mail: _____

Authorized Person to discuss your medical condition:

Name of Person **Relationship** **Phone #**

_____

_____