Patient Demographic Form 個 人 資 料

Last Name: _____ First Name: _____
Chinese Name: _____

(姓) (名) (中 文 姓 名)

Date of Birth: _____ Gender: _____ SSN:
_____

(出生日期) (性別) (社會安全號碼)

Race: (種族) African American Asian Caucasian Hispanic
Native American

Marital Status (婚 姻 狀 況): Single (單身) Married (已婚) Divorced
(離婚) Widowed (喪偶)

Address: _____ Apartment/Room #:
_____

(住址) (房間號碼)

City: _____ State: _____ Zip
Code: _____

(城市) (州) (郵遞區號)

Home Phone: _____ Cell Phone: _____ E-Mail:
_____

(住家電話) (手機電話) (電子郵件)

Highest Level of Education: Grade School High School College
Graduate/Professional Degree

(最高教育程度) (小學) (高中) (大學) (專業學位)

Name of Spouse: _____ Phone: _____

(配偶姓名) (電話)

Emergency Contact Name: _____ Phone: _____ Relationship: _____

(緊急聯絡人姓名) (電話) (關係)

Current Employment: Full Time Part Time Retired Student Unemployed Disabled

(工作狀況) (全職)(兼職) (退休) (學生) (失業) (殘疾)

Name of Employer: _____ Phone: _____

(雇主) (電話)

Address: _____ City: _____ State: _____ Zip Code: _____

(雇主地址) (城市) (州) (郵遞區號)

Occupation: _____ Primary Language: Cantonese Mandarin English

(職業) (第一選擇語言)(廣東話)(普通话)

Primary Care Physician: _____ Phone: _____

(家庭醫生) (電話)

Address: _____

(家庭醫生地址)

IF THIS IS AN INDUSTRIAL INJURY ACCIDENT, PLEASE LET US KNOW AS THEIR ARE ADDITIOINAL FORMS WHICH NEED TO BE COMPLETED.

IMPORTANT OFFICE POLICY: INSURANCE IS METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE PHYSICIAN. IT IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY A FIXED ALLOWANCE FOR PROCEDURES; OTHERS PAY A PERCETAGE OF CHARGES.

PAYMENT IS DUE AT THE TIME OF SERVICE.

I HEREBY ASSIGN MY MEDICAL INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. WENWU JIN'S PRACTICE. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES, CO-PAYMENTS AND DEDUCTIBLES. I ALSO AUTHORIZE DR. WENWU JIN TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.

Signature: X_____ Date: _____

(病人簽名) (日期)

Acknowledgment of Receipt of Notice of Privacy Practices:
(簽收隱私慣例的通知)

I acknowledge that I have reviewed and/or received a copy of Dr. Wenwu Jin's notice of Privacy Practices. This notice describes how Wenwu Jin, M.D., Ph.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I understand that The Notice of Privacy Practices may be revised from the time to time and that I am entitled to receive a copy of The Notice of Privacy Practices. I understand a copy of the most current version of this practice's Privacy Practices in effect will keep in the HIPAA Binder store inside the office.

Signature: X_____ Date: _____

(病人簽名) (日期)

If not sign by patient: Reason why patient can't sign: _____Relationship to Patient: _____

Please check all problems that apply to you: 請 在 每 題 中 選 擇 合 適 答 案. 可 以 選 擇 多 個 答 案.

General: (一 般) Cardiovascular: (心 血 管)

□ recent weight gain 體 重 上 升 □ chest pain 胸 痛

□ recent weight loss 體 重 下 降 □ heart attack 心 臟 病

□ appetite change 胃 口 改 變 □ palpitations (irregular heart beat) 心 跳 不 正 常 (心率異常)

□ difficulty sleeping 睡 眠 困 難 □ heart failure 心 臟 衰 竭

Endocrine & Metabolic: (內 分 泌 和 新 陳 代 謝) □ edema (leg swelling) 水 腫 / 腳 腫

□ sugar diabetes 糖 尿 病 □ high blood pressure 高 血 壓

□ goiter 甲 狀 腺 腫 □ leg cramps with walking 行 走 時 腿 部 抽 筋

□ thyroid problem 甲 狀 腺 問 題 Gastrointestinal: (腸 胃)

□ sterility 不 育 /不 孕 □ heartburn/indigestion 心 口 灼 熱

□ cholesterol/lipid problem 膽 固 醇 / 脂 肪 問 題 □ difficulty swallowing 吞 嚥 困 難

Hematopoietic/Lymphatic: (淋 巴) □ stomach pains 胃 痛

□ anemia 貧 血 □ ulcers 潰 瘍

□ lymph node enlargement 淋 巴 腺 腫 大 □ nausea/vomiting 噁 心 / 反 胃

□ bleeding problem 出 血 問 題 □ diarrhea 腹 瀉

□ frequent infections 經 常 感 染 □ hemorrhoids 痔 瘡

Musculoskeletal: (肌 肉 與 骨 胳 系 統) □ rectal bleeding 直 腸 出 血

□ joint pain 關 節 痛 □ black bowel movements 大 便 有 血

□ joint swelling or warmth 關 節 腫 脹 或 發 熱 □ change in bowel habits 大 便 習 慣 改 變

□ joint stiffness 關 節 僵 硬 □ constipation 便 秘

□ muscle pain 肌 肉 痛 □ frequent laxative use 經 常 使 用 通 便 劑

□ weakness 虛 弱 無 力 □ jaundice or hepatitis 黃 疸 病 / 肝 炎

□ back pain 背 痛 □ liver trouble 肝 病

□ joint deformity 關 節 病 變 □ gallbladder problems 膽 囊 問 題

Psychiatric: (精 神 病) Neurologic: (神 經 系 統)

□ anxiety 焦 慮 / 苦 悶 □ headaches 頭 痛

□ depression 抑 鬱 病 / 憂 鬱 症 □ dizziness 頭 昏 眼 花

□ been seen by a psychiatrist 曾 接 受 精 神 科 醫 生 醫 治 □ blackouts 暫時失去視覺或知覺

Pulmonary: (肺 部) □ numbness and tingling 麻 木 / 刺 痛

□ shortness of breath 喘 氣 □ paralysis 麻 痺, 癱 瘓

□ cough 咳 嗽 □ convulsions/seizures 痙 攣 / 發 羊 吊

□ sputum 痰 □ coordination trouble 協 調 困 難

□ bronchitis 支 氣 管 炎 Medical Condition History: (其 他 病 歷)

□ asthma 哮 喘 □ Alzheimer’s Disease 老 年 癡 呆 症

□ night sweats 盜 汗 □ Cancer 癌 症

Genitourinary: (泌 尿 生 殖 器) □ Coronary Artery Disease (Angina) 心 絞 痛

□ burning with urination 排 尿 時 有 灼 痛 感 □ Other Endocrine Disorder 其 他 內 分 泌 失 調

□ frequency of urination 尿 頻 □ Cerebrovascular Disease (Stroke) 中風

□ wetting pants or bed 褲 濕 / 尿 床 □ Emphysema (COPD) 肺 氣 腫

□ bloody urine 血 尿 □ Parkinson’s Disease 帕 金 森 氏 病

□ sexual difficulties 性 交 困 難 □ Kidney Failure 腎 衰 竭

□ difficulty starting urine 排 尿 困 難 □ Liver Disorder (Cirrhosis) 肝 病

Have you had surgery? 你 是 否 曾 經 有 過 手 術 ? Yes 是 No否

_____
_____
_____

Medication List (請列出你的藥物名稱)

Drug Name: _____ Dosage: _____ How often you take the medication: _____

(藥物名稱) (劑量) (如何服用)

Drug Name: _____ Dosage: _____ How often you take the medication: _____

(藥物名稱) (劑量) (如何服用)

Drug Name: _____ Dosage: _____ How often you take the medication: _____

(藥物名稱) (劑量) (如何服用)

Drug Name: _____ Dosage: _____ How often you take the medication: _____

(藥物名稱) (劑量) (如何服用)

Drug Name: _____ Dosage: _____ How often you take the medication: _____

(藥物名稱) (劑量) (如何服用)

Drug Name: _____ Dosage: _____ How often you take the medication: _____

(藥物名稱) (劑量) (如何服用)

Preferred Pharmacy: _____ Phone: _____

(喜好的藥房名稱)　　(電話)

Address: _____
_____

(藥房地址)

Allergies: Are you allergic to any medication(s)? (你有藥物過敏嗎?) Yes (有) No (沒有)

If Yes, please specify the name of the medication and reaction: (請 明 確 說 明 哪 種 藥 物 過 敏.)

Name of Medication: _____ Reaction: _____

(藥物名稱)　　(反應)

Name of Medication: _____ Reaction: _____

(藥物名稱)　　(反應)

Family Medical History (家 族 病 史)

○ Cancer (癌症) ○ Diabetes (糖尿病) ○ Heart Disease (心臟病) ○ Stroke (中風)

Father: ○ Alive ○ Deceased Age: (Deceased age or current age if still alive): _____

(父親) (健在) (故世) (年齡-包括健在或故世)

Cause of Death: Unknown Aging Other: _____

(死因) (不知道)(自然過身) (其他)

Mother ○ Alive ○ Deceased Age: (Deceased age or current age if still alive): _____

(母親) (健在) (故世) (年齡-包括健在或故世)

Cause of Death: Unknown Aging Other: _____

(死因) (不知道)(自然過身) (其他)

Habits (飲 酒 和 抽 煙 習 慣)

Alcohol: ○ I drink alcohol ○ I used to drink alcohol ○ I have never drunk alcohol

(飲酒) (我飲酒) (我曾經飲酒) (我從不飲酒)

If you drink alcohol, or used to drink alcohol, how many drinks do you have a week on average? _____

(每週飲酒多少)

Years in pattern: (多長時間) _____

Tobacco: ○ I use tobacco ○ I used to use tobacco ○ I have never used tobacco

(抽煙) (我抽煙) (我曾經抽煙) (我從不抽煙)

If you use tobacco, or used to use tobacco, how much do you/did you use?

How many packs/day: _____ Years in pattern: _____
Stopped date: _____

(每日抽煙多少) (多長時間) (終止日期)

Current daily caffeine use: (每 日 咖 啡 因 攝 取 量) (1 cup = 8 ounces), (1 glass = 12 ounces)

Coffee cups per day: _____ Tea glasses per day: _____
Soda glasses per day: _____

(咖啡) (茶) (汽水)