PATIENT INFORMATION FORM 病人資料表

Patient Name (姓名)_____

病人中文姓名_____

Date of Birth (生日) _____Sex O M 男 O F 女

Address (地址)_____

City (城市) _____

State (州) _____ Zip(郵政號碼) _____

Emergency Contact (緊急聯絡人) _____

Relationship (與病人關係)_____

Phone Number (電話) _____

Social Security (社安卡號) _____

Home Phone (家裡電話) _____

Business/Cell (工作/手機號碼) _____

Employed by (公司名稱) _____

Business Address (工作地址) _____

_____

Referred By (介紹人) _____

Referring M.D.(介紹醫師) _____

Medical M.D.(家庭醫師) _____

PRIMARY INSURANCE 主要保險

Policy #(保險卡號碼) _____

Insured (受保人) _____

Relationship to Insured (與病人關係) _____

Insurance Co.(保險公司名稱)_____

Address (地址)_____

City (城市) _____ State(州) ____Zip(郵政號碼) _____

Phone # 保險公司電話 _____

Were you injured on the job (因工作受傷)? O yes 是, O no 不是

Worker's Compensation # (工作傷害保險#)_____

Date and Time of Injury (受傷時間和日期) _____

SECONDARY INSURANCE 第二保險

Policy # 保險卡號碼 _____

Insured (受保人) _____

Relationship to Insured (與病人關係) _____

Insurance Co. 保險公司名稱_____

Address (地址)_____

City (城市) _____ State (州) ____Zip(郵政號碼) _____

Phone # (保險公司電話) _____

Were you in an auto accident (因車禍受傷)? O yes 是 O no 不是

No Fault case or File No. _____

NOTES:

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for Neuro Health P.C.

_____ _____

Signature of Patient Date

I hereby authorize Jyh Lu, M.D. to furnish information concerning my illness and treatment to my insurance carriers. I further release my pre, intra, and post-operative photographs and/or videos for publications, the rendering of care, or education purposes.

I hereby authorize payment of medical benefits to Jyh Lu, M.D.

I request that payment of authorized Medicare benefits by made either to me or on my behalf to Dr. Jyh Lu for services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-ins, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Authorized Signature Date