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FLUSHING, NY 11354
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Patient Name (病人姓名) _____
Last Name (姓) First Name (名) （中文名字）

Address (地址) _____ Phone Number (聯絡号码) _____

_____ Cell Number (手机号码) _____

Sex (性别): ☐F (女) ☐ M (男) Age _____ Birthday (生日) _____

Married (已婚), Single (单身), Widow (丧偶), other (其它) Occupation (职业) _____

Emergency Contact person & number (緊急聯繫人及电话号码) _____

Pharmacy Name (药房) _____

Primary Insurance (主要保險) _____ Policy Number (保單號) _____
Insured Name (受保人) _____ Insured Date of Birth (受保人出生日期) _____

Secondary Insurance (第二保險) _____ Policy Number (保單號) _____
Insured Name (受保人) _____ Insured Date of Birth (受保人出生日期) _____

SSN (社會安全號) _____

May we discuss your report with any family members or relatives? ☐ Yes or ☐ No
我們是否可以同你的家人或朋友討論你的檢驗報告？ 同意 或 不同意

I, _____ , hereby certify the above information about myself and insurance are
我, _____ 在此承諾我以上所提供的個人及保險資料準確無誤，我在此授權吳旭霞內
accurate and current. I authorize Jason Yu M.D., P.C. to file all necessary medical claims to my
科家庭醫生診所向我的保險公司所呈報的各項醫療項目同時也同意由吳旭霞內科家庭醫生診所向保險公司提供保
insurance company and provide any medical record to insurance company when requested. If my insurance becomes
險公司所需要的個人醫療記錄。如果我的保險失效或過期我願意承擔吳旭霞內科家庭醫生診所所有醫療項目的費
inactive, I will be responsible for all charges billed. I here authorize and direct my insurance carrier to issue check directly
用。我同意將保險所支付的所有費用直接支付到吳旭霞內科家庭醫生診所。
to Jason Yu M.D., P.C.

Patient's Signature (病人簽名) _____ Date (日期) _____

Witness's Signature (見證人簽名) _____ Date (日期) _____