ATLANTA PRIME MED- Patient Information Form

5008 Buford Hwy Suite A Chamblee GA 30341

P: 770-451-1146 F: 678-534-3701

Date 日期: _____/_____/_____

Name 名稱 : Status (Married, Single Widowed, or Divorced)

_____ ❑M 已婚 ❑S 單 ❑W 寡 ❑D離婚

Last 姓 First 名字 M. I.

Birthdate 生日:_____/_____/_____ S.S#____-____-_____ ❑No S.S

Age年齡:____ years or _____ months Gender/性別: ❑Female 女性 ❑Male 男性

Address 地址: _____

Phone Number 電話號碼: _____-_____-_____

Emergency Contact's Name 緊急聯絡人姓名:_____

Phone Number 電話號碼: _____-_____-_____

Reason for today's visit今天訪問的原因:_____

How did you hear about this clinic/你是怎麼聽說這個診所的?

_____

Describe your current symptoms briefly/ 簡要描述您目前的症狀:

_____

Do you have insurance 你有保險嗎? ❑Yes是 ❑No, I will pay myself. 不，我會付錢給自己

I understand that by signing below I agree that the form has been filled to the best of my ability and to pay all medical expenses incurred for services provided to me

Signature: _____

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PAST MEDICAL HISTORY/過去的醫療歷史

Please √ you now or have you ever had/ 請√你現在還是曾經有過 :

___Anemia/貧血

___ Angina/心絞痛

___ Asthma/哮喘

___ Cataracts/白內障

___ Cancer (type) _____
癌症（類型）_____

___ Colitis/結腸炎

___ Crohn's disease/克羅恩病

___ Diabetes/糖尿病

___ Emphysema/肺氣腫

___ Epilepsy (seizures)/ 癲癇（癲癇發作）

___ Goiter/甲狀腺腫

___ Heart murmur/心臟雜音

___ Heart problems/心臟問題

___ Hepatitis/肝炎

___High blood pressure/高血壓

___ High cholesterol/高膽固醇

___HIV/AIDS; HIV 愛滋病

___Hypothyroidism

___Jaundice/黃疸

___ Kidney disease/腎臟疾病

___ Kidney stones/腎結石

___ Leukemia/白血病

___Pneumonia/肺炎

___ Psoriasis/牛皮癬

___ Pulmonary Embolism/肺栓塞

___ Rheumatic fever/風濕熱

___ Stroke/ 中風

___ Stomach or peptic ulcer/胃或消化性潰瘍

___ Tuberculosis/結核病

Other medical conditions (please list):

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Personal History/個人歷史

Were there problems with your birth? (Specify)/ 你的出生有問題嗎? 請註明

Where were your born & raised? / 你出生和成長的地方？

What is your highest education? 你的最高教育是什麼？

FAMILY HISTORY/ 家史				
	IF LIVING/如果生活		IF DECEASED/如果失敗了	
	Age (s)/ 年齡	Health & Psychiatric	Age(s) at death/ 死亡時的年齡	Cause/原因
Father 父親				
Mother 母親				
Siblings 兄弟姐妹				
Children 孩子				
PSYCHIATRIC PROBLEMS PAST & PRESENT/ 延伸家庭心理問題過去和現在：				

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System Review/ 系統評論

In the past month, have you had any of the following problems?
過去的一個月裡，您是否遇到過以下任何問題？

GENERAL/一般

❑ Recent weight gain; how much/ 最近的體重增加;多少

_____

❑ Recent weight loss: how much/ 最近的體重增加;多少 _____lbs

❑ Fatigue/ 疲勞

❑ Weakness/ 弱點

❑ Fever/ 發燒

❑ Night sweats/盜汗

MUSCLE/JOINTS/BONES 肌肉/接頭/骨頭

❑ Numbness 麻木

❑ Joint pain 關節疼痛

❑ Muscle weakness 肌肉無力

❑ Joint swelling 關節腫脹

Where? 哪裡？

EARS 耳朵

❑ Ringing in ears耳鳴

❑ Loss of hearing 聽力喪失

NERVOUS SYSTEM/ 神經系統

❑ Headaches/頭痛

❑ Dizziness/ 頭暈

❑ Fainting or loss of consciousness/ 暈倒或喪失意識

❑ Numbness or tingling / 麻木或刺痛

❑ Memory loss/記憶喪失

STOMACH AND INTESTINES 胃和腸

❑ Nausea噁心

❑ Heartburn 胃灼熱

❑ Stomach pain 胃痛

❑ Vomiting 嘔吐

❑ Yellow jaundice 黃色黃疸

❑ Increasing constipation 增加便秘

❑ Persistent diarrhea 持續性腹瀉

❑ Blood in stools 糞便中的血液

❑ Black stools 黑色凳子

PSYCHIATRIC

❑ Depression/ 抑鬱症

❑ Excessive worries/ 過度擔憂

❑ Difficulty falling asleep/ 難以入睡

❑ Difficulty staying asleep/ 難以入睡

❑ Difficulties with sexual arousal/ 性喚起的困難

❑ Poor appetite/ 胃口不好

❑ Food cravings/對食物的渴望

❑ Frequent crying/ 頻繁哭泣

❑ Sensitivity/靈敏度

❑ Thoughts of suicide / attempts/關於自殺/企圖的想法

❑ Stress 壓力

❑ Irritability/ 易怒

❑ Poor concentration 注意力不集中

❑ Racing thoughts 賽車思考

❑ Hallucinations幻覺

❑Rapid Speech 快速演講

❑Guilty Thoughts 有罪的想法

❑Paranoia

❑Mood Swings 情緒波動

❑Anxiety

❑Risky Behavior危險行為

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Eyes 眼睛

- ❑ Pain 疼痛
- ❑ Redness 發紅
- ❑ Loss of vision 視力喪失
- ❑ Double or blurred vision 視力雙重或模糊
- ❑ Dryness 乾燥

THROAT 喉

- ❑ Frequent sore throats 經常喉嚨痛
- ❑ Hoarseness聲音嘶啞
- ❑ Difficulty in swallowing 吞嚥困難
- ❑ Pain in jaw 下巴疼痛

HEART AND LUNGS 心臟和肺臟

- ❑ Chest pain 胸痛
- ❑ Palpitations 心悸
- ❑ Shortness of breath 呼吸急促
- ❑ Fainting 暈倒
- ❑ Swollen legs or feet 腿或腳腫脹
- ❑ Cough 咳嗽

SKIN 皮膚

- ❑ Redness 發紅
- ❑ Rash 皮疹
- ❑ Nodules/bumps 結節/凸起
- ❑ Hair loss 脫髮
- ❑ Color changes of hands or feet 手或腳的顏色變化

BLOOD 血液

- ❑ Anemia 貧血
- ❑ Clots 凝塊

KIDNEY/URINE /BLADDER 腎臟/尿/膀胱

- ❑ Frequent or painful urination 頻繁或痛苦的排尿
- ❑ Blood in urine 尿液中的血液

Women Only 僅限女性:

- ❑ Abnormal Pap smear 巴氏塗片異常
- ❑ Irregular periods 不規則的時期
- ❑ Bleeding between periods 期間出血
- ❑ PMS

OTHER PROBLEMS 其他問題:

WOMENS REPRODUCTIVE HISTORY 女性的生殖歷史:

Age of first period
第一期的年齡 _____years

Pregnancies懷孕:
Miscarriages:
Abortions:
Have you reached menopause你到了更年期嗎? Y / N
At what age在什麼年齡?____
Do you have regular periods 你有規律的時期嗎? Y / N

Signature: _____

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CURRENT MEDICATIONS/ **現行藥物**

Drug allergies: ❑ No ❑ Yes 藥物過敏：□否□是什麼？
To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements/請列出您正在服用的任何藥物。包括非處方藥和維生素或補品：:

Name of Drug **藥物名稱**	Dose (include strength & number of pills per day) & How long have you been taking this? **劑量（包括每天的力量和藥丸數量）服用多長時間了？**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

Signature: _____

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Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, any other screening ordered by the doctor or staff. I understand that if I have come for a physical but want further treatment my insurance may not cover such visits and I will be held responsible for the balance. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement. By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Atlanta Prime Med provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Patient Name (and Guardian Name if applicable)

_____

Patient or Guardian Signature

X_____ Date:_____/_____/_____

Our office does not make the rules. They are determined by your specific medical insurance plan.

Signature: _____

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患者責任

我理解並同意，我對所提供的任何和所有服務的所有費用負有經濟責任。這包括任何醫療服務或訪問，例行檢查，醫生或工作人員訂購的任何其他篩查。我明白，如果我來體檢但需要進一步治療，我的保險可能不會涵蓋這些訪問，我將負責餘額。我知道雖然我的保險可以確認我的福利，但確認福利並不能保證付款，我對任何未付餘額負責。我理解並同意，我有責任了解我的保險是否有任何可扣除，共同支付，共同保險，網絡外，通常和慣例限制，事先授權要求或我收到的服務的任何其他類型的福利限制我同意全額付款。我理解並同意，我有責任知道我的保險是否需要我的初級保健醫生轉診，並且由我來獲取轉診。我理解，如果沒有此推薦，我的保險將不會支付任何服務費用，並且我將對所提供的所有服務承擔經濟責任。我同意通知辦公室我的保險範圍有任何變化。如果我的保險在服務時已經更改或終止，我同意我對財務餘額負全部責任。如果我是Medicare患者，我知道我需要向辦公室提供Medicare身份證和我的二級身份證。如果辦公室沒有適當的二級保險信息，則不會向中學人員收取費用。我有責任支付餘額，然後向中學提出索賠報銷。通過簽署此表格，我同意使用和披露有關我的治療，支付和醫療保健操作的受保護健康信息，和/或法律要求。我有權以書面形式撤銷本同意書，並由我簽署。但是，此類撤銷不應影響已根據我之前的同意進行的任何披露。 Atlanta Prime Med提供此表格以符合1996年健康保險流通與責任法案（HIPAA）。

印刷的患者姓名（如果適用，還有監護人姓名）

_____

患者或監護人簽名

X_____ 日期: _____/_____/_____

我們的辦公室沒有製定規則。它們由您的特定醫療保險計劃決定。

Signature: _____