

PACIFIC ORTHOPAEDIC ASSOCIATES

Matthew Lin, M.D. 林元清醫生
Anthony Yang, M.D. 楊培醫生
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David Huang, M.D. 黃威賓醫生
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Shane Pak, M.D.
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Your personal information 個人資料

Date 日期		Provider 主治醫生	
Last Name 姓	First Name 名	Middle Initial 別名	<input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女
Address 住址	City 城市	State 州	Zip Code 區號
Home Phone 家電話:	Social Security # 社安號碼:	Birth Date 出生日	
Spouse Last Name 夫或妻的姓	Spouse First Name 夫或妻的名:	Spouse Middle Initial 夫或妻的別名:	
Work Phone 工作電話:	Alternate Phone 其他電話:	Description 描述:	
Referring Provider 推醫生	Phone 電話		
Referrer's Address 轉診醫生住址	City 城市	State 州	Zip Code 區號
Primary Care Physician 家庭醫生	Phone 電話		
PCP's Address 家庭醫生住址	City 城市	State 州	Zip Code 區號
Pharmacy 藥局:	Phone 電話	Fax 傳真	
Emergency Last Name 緊急聯絡人姓	First Name 名	Middle Initial 別名	Relation 關係:
Address Line 住址1:	Emer. Contact Phone 緊急聯絡電話		
City 城市	State 州	Zip Code 區號	Emergency Alternate Phone 其他緊急電話

Your insurance information 個人保險資料

Primary Insurance Information 主要保險公司資料

Insurance Name 保險公司名字			
Your contract or ID Number 聯絡人或保險號			
Address 住址			
City 城市	State 州	Zip 區號	

Secondary Insurance Information 第二保險公司資料

Insurance Name 保險公司名字			
Your contract or ID Number 聯絡人或保險號			
Address 住址			
City 城市	State 州	Zip 區號	

Is this a work injury 工作傷害嗎? Yes 是 No 否

Workers Compensation Carrier: _____

Were you injured in a motor vehicle accident 車禍受傷嗎? Yes 是 No 否

Insurance Name 保險公司: _____

Primary Subscriber Information 主要保險人資料

Last 姓	First 名	M.I. 別名
Address 住址		
City 城市	State 州	Zip 區號
DOB 生日	<input type="checkbox"/> Male 男	<input type="checkbox"/> Female 女

Secondary Subscriber Information 第二保險公司資料

Last 姓	First 名	M.I. 別名
Address 住址		
City 城市	State 州	Zip 區號
DOB 生日	<input type="checkbox"/> Male 男	<input type="checkbox"/> Female 女

Date of Injury 受傷日 _____

Phone 電話: _____

Date of Injury 受傷日 _____

Phone 電話: _____

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Your Medical History 背景

Last Name 姓 _____ First Name 名 _____ Middle Initial 別名 _____ DOB 出生日: _____

Have you been diagnosed with any of the following problems? Please check the appropriate answer 有下列疾病請打勾。

AIDS/HIV 愛滋病 <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clots 凝血症 <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression 憂鬱症 <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis 肝炎 <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism 酒精中毒 <input type="checkbox"/> Yes <input type="checkbox"/> No	CA Colon 腸癌 <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes 糖尿病 <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease 腎病 <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's 腦退化症 <input type="checkbox"/> Yes <input type="checkbox"/> No	CA Lung 肺癌 <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Abuse 物藥濫用 <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoarthritis 骨關節炎 <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia 貧血症 <input type="checkbox"/> Yes <input type="checkbox"/> No	CA Breast 乳癌 <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout 痛風 <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures 癲癇症 <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis 關節炎 <input type="checkbox"/> Yes <input type="checkbox"/> No	CA Prostate 前列腺癌 <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease 心臟疾病 <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers 潰瘍 <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma 哮喘病 <input type="checkbox"/> Yes <input type="checkbox"/> No	COPD 慢性肺障疾病 <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension 高血壓 <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: 其他 <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Diseases 其他疾病 _____		Other Fractures: 其他骨折 _____	
		<input type="checkbox"/> Right Handed 右手	<input type="checkbox"/> Left Handed 左手

Please describe your past orthopaedic problems 描述過去骨的問題

Current Medications list any medications you are currently taking, 目前服那些藥

including dosage and frequency (include oral contraceptives) 寫下計量和次數包括口服避孕藥

Please list any major surgical procedures you've had 寫下你曾經開過的刀

1. _____	Date _____	Allergies
2. _____	Date _____	
3. _____	Date _____	
4. _____	Date _____	
5. _____	Date _____	

Are you allergic to any medications / drugs? 對任何藥過敏嗎 Yes No

If yes, please specify. 是, 請註明

Have you ever had any complications from anesthesia? 你曾對麻藥反應嗎 Yes No

Your Family History 家庭背景

Has anyone in your immediate family had any major illnesses? Please check the appropriate answer. 家庭成員有下列疾病請打勾

AIDS/HIV 愛滋病 <input type="checkbox"/> Yes <input type="checkbox"/> No	CA Colon 腸癌 <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Abuse 物藥濫用 <input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Disease 肌肉疾病 <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism 酒精中毒 <input type="checkbox"/> Yes <input type="checkbox"/> No	CA Lung 肺癌 <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout 痛風 <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis 骨質疏鬆 <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's 腦退化 <input type="checkbox"/> Yes <input type="checkbox"/> No	CA Breast 乳癌 <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease 心臟疾病 <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoarthritis 骨關節炎 <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia 貧血症 <input type="checkbox"/> Yes <input type="checkbox"/> No	CA Prostate 前列腺癌 <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension 高血壓 <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures 癲癇症 <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis 關節炎 <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression 憂鬱症 <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease 腎疾病 <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers 潰瘍 <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma 哮喘病 <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes 糖尿病 <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease 肝臟疾病 <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Diseases 其他疾病: _____		Other Fractures: 其他骨折 _____	

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Your Social History

Last Name 姓		First Name 名		Middle Initial 別名		DOB 生日:	
Occupation 職業:				Employer 雇主:			
Education 教育:				<input type="checkbox"/> Retired 退休		<input type="checkbox"/> Disabled 殘障	
Marital Status 婚姻狀況:		<input type="checkbox"/> Married 結婚		<input type="checkbox"/> Divorced 離婚		<input type="checkbox"/> Single 單身	
				<input type="checkbox"/> Widow(er)			

Other Considerations:

Do you smoke 抽煙? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily Usage 日抽幾枝	Drink Alcohol 喝酒? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily Usage 日喝幾杯
Drink caffeine 咖啡因? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily Usage 日喝幾杯	Do you use street Drugs 吸毒? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type/Daily Usage 種類/日用多少
Are you pregnant 懷孕? <input type="checkbox"/> Yes <input type="checkbox"/> No	Supplemental Medications 補藥? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a hysterectomy 子宮切除? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 無	
Are you going through Menopause 快更年期? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 無		Have you gone through Menopause 更年期過? <input type="checkbox"/> Yes 有 <input type="checkbox"/> No 無	

Lifestyle 生活形態:

Activity Level 活動程度 <input type="checkbox"/> Above Average 平均以上 <input type="checkbox"/> Average 平均 <input type="checkbox"/> Sedentary 少動	Exercise Frequency 運動頻率: <input type="checkbox"/> 2-3次/week 週 <input type="checkbox"/> 3-4次/week 週 <input type="checkbox"/> 5次/week 週 <input type="checkbox"/> Daily 每日 <input type="checkbox"/> Never 從不 <input type="checkbox"/> Occasional 偶爾
Type of Exercise 何種運動:	Hobbies 嗜好/Activities 社交活動:

Commercial insurance I hereby consent to Pacific Orthopaedic Associates using and/or disclosing my protected health information ("PHI") for my care, and the Practice's health care operations, and for such other uses that are permitted or required under federal or state law without my consent or authorization. Specifically, I authorize release of information necessary to file a claim with my insurance company and assign payment of benefits to the physician indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier.
本人同意讓信安醫院在法律許可內做各種醫療服務及使用個人資料向保險公司申請你的醫療費並同意支付保險不包的費用

In the event of my failure to pay any sums due and my account is referred to an attorney for collection, I agree to be responsible for reasonable attorney's fees. A copy of my signature below is as valid as the original. Medicare I further certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims for payment purposes.
如果本人不付費而至訴訟同意支付訴訟費用,本人所簽名的正副本有相同法律效力,提供的文件是正確的和使用個人資料向Medicare司申請你的醫療費

Signature 簽名

Date 日期

Please Initial
簽名縮寫

I authorize treatment of the person named above and agree to pay all fees and charges of such treatment. I agree to pay charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing
本人同意接受醫療,個人與家人並同意支付醫療費除非事先協商寫下支付方式

Please Initial
簽名縮寫

Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect and unpaid balance due for medical services rendered to me or my family, I/We agree to pay reasonable attorney's fees or other such costs as the the court determines proper.

Please Initial
簽名縮寫

帳單如有錯誤請在三十天內更正不然以帳面上金額為準如果不付費而至訴訟同意支付訴訟費用
It is agreed that payments will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.
reasonable attorney's fees or other such costs as the the court determines proper.

Please Initial
簽名縮寫

本人同意不拖延應付款和不得拒付因保險給付未准的款項如果不付費而至訴訟同意支付訴訟費用
Patients are responsible for all DEDUCTIBLE AMOUNTS and OUT-OF-NETWORK CHARGES which are not covered by Insurance Companies.
本人同意支付自付額和所有保險不包的費用