# Medical Physicians Group PLLC


## 8563 Argyle Business Loop Suite #2, Jacksonville Florida 32244

## Phone # 863-874-0898

## Fax # 833-728-7733


## Health Insurance Portability and Accountability Act (HIPPA) Acknowledgement

## 健康保险流通与责任法案

**I have received the HIPAA information. I understand that Medical Physicians Group PLLC and Dr. Leung will make all attempts to protect patient's medical information**

我已经收到了健康保险流通与责任法案的信息. 我了解 Medical Physicians Group PLLC PLLC 和梁医生将尽一切努力保护病人的医疗信息.

_____

**Print 名字**

_____ _____

**Sign 病人签名** **Date 签名和日期**

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# Cancellation Policy and Payment Policy

# 取消预约和付费信息

**I understand that there is a $25 for any cancellation less than 24 hours prior to the appointment. I understand if insurance does not pay for your benefits and/or if your benefits have expired, then it is the patient's responsibility to pay for the office visit and/or the procedure, vaccination, and/or any medical services rendered.**

我了解在预约之前的24小时内，任何取消均需支付25美元。我了解如果保险不能支付患者的就诊费，或者保险已经过期，那么患者有责任支付就诊费用，医疗程序，接种疫苗 和诊所提供的任何医疗服务。

_____

**Patient's name 病人名字**

_____ _____

**Patient's Signature 病人签名** **Date 病人签名和日期**

# Medical Physicians Group PLLC New Patient Information Form

**Patient's Legal Name 姓名:** _____

**Guardian/Responsible Party (if any)监护人:**_____

**Patient's Date of Birth 出生年月日:** _____

**Patient's Social Security Number 工卡号码:** _____

**Patient's Address 住址**_____

**Patient's Telephone Number 电话号码:** _____

**Emergency Contact Name and Relation to Patient紧急联系人的名字 和 关系:**

_____

**Emergency Contact's Phone Number 电话号码:**

_____

**Date of Last Physician Visit (Known or Approximate)上一次看医生时间:**

_____

**Name of Last Physician Seen 医生的名字:**

_____

**Physician Phone Number医生的电话号码:**

_____

**Reason for Last Office Visit上一次看医生的原因:**

_____

**Primary Care Physician's Name (if different from above) 家庭医生的名字（如果和上面填的不一样）:** _____

**Primary Care Physician's Phone Number 家庭医生的电话号码:**

_____

**Patient's Signature 病人签名**_____

**Date 日期**_____

**Date Last Seen by Primary Care Physician 上一次看家庭医生的时间:**

**_____**

**Patient's Primary Pharmacy Address 病人的药房地址:**

**_____**

**Primary Pharmacy Telephone 药房电话号码:**

**_____**

**Patient's Signature 病人签名_____**

**Date 日期_____**

# Allergy and Drug Information- New Patient

# 过敏和药物信息-新患者

**Do you currently have any known allergies?** 您目前有任何已知的过敏反应吗？

Yes 是 No否

**If so, please list all known allergies (food allergies included) 如果是，请列出所有已知的过敏症（包括食物过敏症）** _____

**For females, when was your last menstrual period 女性病人，上一次月经是什么时候?**

**For females, Is there a chance that you can be pregnant 女性病人，您是否有可能怀孕?**

**Please list all medications taken. Include name of medication (including strength), physician's name who prescribed the medication, date of last refill, and how often you take this medication. This includes prescription medication, medical supplements (both physician and non-prescription prescribed), and any recreational drugs. Please include drug name, dosage, and frequency and what time periods the drug was taken.**

请列出所有服用的药物。
包括药物名称（包括强度），开具药物的医师姓名，最后补充的日期以及您服用此药物的频率。
这包括处方药，医疗补品（包括医师和非处方药）以及任何娱乐性药物。
请包括药物名称，剂量和频率以及服用时间。

_____

_____

_____

**Patient's Signature 病人签名**_____

**Date 日期**_____

**By completing the above information, you acknowledge the following:** All prescribed and non-prescribed medications taken, including their current dosages and strengths, have been truthfully stated on this form. Should our physician prescribe medication which could cause a reaction with any unknown substances at the time of prescription, the patient agrees to hold harmless said physician.

通过完成上述信息，您将确认以下内容：所用的所有处方药和非处方药，包括其当前剂量和强度，均已在此表格中如实说明。 如果我们的医生开出的处方可能是与任何未知物质发生反应的药物，则患者同意和该医生无关。

If there is any change in medication taken from another provider, or another provider issues a new or change of prescription, it is up to the patient to notify us to update this change in his/her medical records and advise patient regarding any possible drug interactions.

如果您从另一位医师那里服用的药物发生任何变化，或者另一位医师开了新药或变更了处方，则病人应通知我们更新其病历中的这一改变，并就可能的药物相互作用向病人提供建议 。

**Signature of Patient or Patient's Representative 病人或者其代表人:**

_____

**Date Signed日期:** _____

**Reason for Today's Visit 今天就诊的原因:**

_____

_____

**Please Circle and Elaborate if You Have Seen a Physician For or Have Been Diagnosed with Any of the Following:**

如果您看过医师或被诊断患有以下任何一种疾病，请圈出并详细说明：

**Arthritis 关节炎**_____

**Blurry Vision 视力模糊** _____

**Cancer 癌症**_____

**Chest Pain 胸口疼**_____

**Circulation Issues血液循环问题**_____

**Diabetes糖尿病**_____

**Digestive Issues消化问题**_____

**Dizziness 头晕** _____

**Fatigue 疲劳**_____

**Female Health/Gynecological 女性保健/妇科**_____

**Heart Conditions 心脏状况**_____

**High Cholesterol 高胆固醇**_____

**High Blood Pressure 高血压**_____

**Hormonal Issues 荷尔蒙问题**_____

**Incontinence 失禁**_____

**Patient's Signature 签名**_____

**Date日期:**_____

**Insomnia 失眠**_____

**Low Blood Pressure 低血压**_____

**Male Health 男性健康**_____

**Mental Health Conditions 精神健康状况** _____

**Migraines 偏头痛**_____

**Pain (describe location) 疼痛（描述位置）** _____

**Paralysis 麻痹**_____

**Respiratory Conditions (including Asthma and Shortness of Breath) 呼吸系统疾病（包括哮喘和呼吸急促）** _____

**Seizures 癫痫发作**_____

**Substance Abuse/Chemical Dependency 物质滥用/化学依赖性** _____

**When was last menstrual period？ 上一次月经是什么时候？** _____

**Are you in Menopause？ 您正处于更年期吗？** _____

**Is there a chance you can be pregnant？ 您是否有可能怀孕?** _____

**Please list any Surgeries (both Inpatient and Outpatient), and Their Dates**

请列出所有手术（住院和门诊）及其日期

_____

_____

_____

**Patient's Signature 病人签名**_____

**Date 日期**_____

**Do you currently use any medical devices? This includes assistive devices used as needed or prescribed regular use equipment. Some examples can include a nebulizer, CPAP machine, walker/cane, oxygen system, etc. If so, please list below：**

您目前是否使用任何医疗设备？ 这包括根据需要使用的辅助设备或规定的常规使用设备。一些示例包括雾化器，CPAP机器，助行器/拐杖，氧气系统等。如果是，请在下面列出

_____

_____

**I hereby attest to the best of my knowledge, all above statements regarding my previous known health conditions have been disclosed and answered truthfully.**

我在此证明，以上关于我以前已知的健康状况的所有陈述均已得到披露并如实回答。

**Patient's Signature 病人签名:**_____

**Date 日期 :**_____

# Insurance Information

# 保险信息

**Primary Insurance Company's Name 主要保险公司的名字**_____

**Group Number 组号:** _____ **Policy Number 保单号码 :**_____

**Policy Holder's Name 保单持有人姓名**_____

**Policy Holder's SSN保单持有人工卡号码:** _____

**Relation to Patient: 保单持有人和病人的关系**_____

**Policy Holder's Place of Employment 保单持有人的工作地点:**_____

**Phone Number电话号码:**_____

**Policyholder's Address保单持有人的地址:**

_____

_____

**Secondary Insurance Company Name 二级保险公司名字:** _____

**Group Number 组号:** _____ **Policy Number保单号码:**_____

**Policyholder's Name 保单持有人名字:** _____

**Patient's Signature 病人签名**_____

**Date 日期**_____

**I hereby attest that all insurance information is truthful and current. If insurance information is unable to be verified at time of appointment, or a company rejects any claim, it is up to the patient or patient' representative to pay via cash and perform a self-claim filed with their own insurance company for self-reimbursement.**

我在此证明，所有保险信息都是真实和最新的。
如果在预约时无法核实保险信息，或者公司拒绝任何索赔，则由病人或
病人代表自行决定以现金付款并向其自己的保险公司提交自我索赔以进行自我补偿 。

**Patient or Patient's Representative Signature**_____

**病人或病人代表签字**

**Date 日期**_____