Mercer Island Community Family & Internal Medicine Clinic

New Patient Intake Form 新病人登记表格

Today's Date(MDY) 今天日期（月日年） / /

LastName (English) 姓（上面请写英文，这写中文）	**First (English)** 名	**Middle**

BirthGender 出生性别	Circle one Male 男 Female 女 **Assigned gender if different**:
Birthdate 生日	Month 月 Day 日 Year 年 | **Today's age** 今天年纪
Cell # 手机	To receive appointment reminders, weather cancellations, and other visit related notices. Test results will not be left on voicemails nor sent via email 诊所会用这些联络方式提供预约提醒或其他预约信息。诊所不会在电话录音或邮件里发测验信息
Email 邮件	
Address 住址 If mailing address different, please also list	

Country of Birth________________
出生国家

Countries you lived in for long than 7weeks______________________________________
其他您住超过 7 周的国家

Allergies to Medications 药过敏____

Allergies, other: 其他过敏____

Past Medical History Please circle all issues and note year issue started **病史:** 请圈以往病史与填那一年开始的

	Year 年		**Year 年**		**Year 年**
Asthma 哮喘		Heart Problems 心脏病		Skin Problems 皮肤病	
Bladder or Prostate 膀胱或前列腺		High Blood Pressure 高血压		Sleep problems, more than 2x/wk 睡眠问题，一周超过两次	
Brain Injury 脑疾病		High blood sugar 高血糖		Others 其他	
Broken bones 骨折		Kidney Problems 肾病			
COPD/Emphysema 肺气肿		Liver problems 肝病			
Ear Problems 耳疾病		Lung Problems 肺病			
Eye Problems 眼疾病		Muscle Problems 肌肉疾病			

Medications & Supplements you use at least once a week 一周服用超过一次的药，维生素或补品

____

Humans are social and those around us help us stay healthy. The information below helps us take better care of you
您的家庭成员信息

a. Who do you live with more than once a week? Please note more members in another page if needed
请问谁跟您住一起 。如果有更多人，请用另一张纸。

First Name/Last Name 姓名	**Gender 性别**	**Relation 关系**	**Current Age 年纪**

b. Who are your close adult friends and/or relatives? Please note more members in another page if needed
请问谁是您家里以外的成人朋友或亲戚 。如果有更多人，请用另一张纸。

First Name/Last Name 姓名	**Gender 性别**	**Relation 关系**	**Current Age 年纪**

Anything else you wish to share that may affect our care for your health? (eg. Afraid of needles, nausea with antibiotics)
有其他可能影响您健康的信息吗？（如 怕针，吃抗生素会反胃）

____

You authorize us to discuss your medical concerns with the adult (+18yo) below if you are not available: Leave blank if none
您授权我们同以下成人讨论您的医疗信息如果您没接电话。 如果没有人授权，请留空

Last Name 姓______________________ First Name 名____________________ Phone number 电话_________________________

Mercer Island Community Family & Internal Medicine Clinic

Medical Care, Privacy and Financial Policies Agreement

医疗，隐私，与收费协议

Patient's Last Name 姓	**First Name** 名	**Age** 年纪

If patient is under 18 years old or in care of a guardian, below is guardian who will usually accompany patient and is signing below. If there are more guardians, please provide information separately. 如果患者未到 18 岁或者是有监护人的成人，请填一般会陪从患者的监护人信息

Guardian Last Name 监护人姓	**Guardian First Name** 监护人名
Age 年纪	**Relation to Patient** 与患者关系
Cell phone 手机	**Home Phone** 家里电话
If lives at different address, please list address 如果住址跟患者有差异，请写监护人住址	
If patient is 18years or older, please list reason(s) guardian is needed 如果患者是成人，请写需要监督人原因	

Agreement of Mutual Responsibility and Understanding of the Limits of Medicine

The undersigned or patient's guardian hereby authorizes Community Family and Internal Medicine, LLC, to provide medical care. Dr. Fang pledges to provide the most appropriate medical care possible. Patient and any guardians will in turn provide all necessary information and cooperate with medical advice. Patient and guardians understand that disease processes may vary in presentation due to timing and person to person variability. Long term relationship and timely follow up can decrease missed diagnoses and/or allow a change in treatment plan in a timely manner

互相责任与理解医疗有限同意书

以下患者授权 Community Family and Internal Medicine, LLC 提供医疗服务。方医生承诺尽力提供最适当的医疗服务。患者和监督人会提供全部有关信息与配合治疗。患者与监督人理解疾病的病程可能会因个人因素而有差异。长期医护关系与及时跟踪可以减低误诊和及时更改治疗方案

Privacy Dr. Fang takes your privacy seriously and complies to the best of her ability to privacy requirements as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), enforced by the US Department Health and Human Services (hhs.gov/hippa). Please note if someone is within earshot when you are discussing medical issues (eg.you bring a friend into the exam room), it is assumed that you are waiving your privacy in those instances.

- *If you email/text the clinic, you may get a reply even if you may not have secured/HIPPA compliant email/text.*

*If you **do not want** to receive non-secured email or text, please sign here* ______________________________

Alternatives include communicating by HIPPA compliant Fax and by phone. Communication with referring or referred health care providers do not require consent.

隐私权 方医生尊重您的医疗隐私并且会尽力遵守美国健康局定的医疗法名 **Health Insurance Portability and Accountability Act of 1996 (HIPPA)**。请注意如果您在其他人附近谈您的医疗事故（列：您带您的朋友一起会诊），这默认您放弃您有关的隐私权。

- 如果您用没有特别批准的医疗隐私邮箱或短信发信息给诊所，此诊所可能会回您。
  如果您不希望收回应，请在此签名
  您也可以用 **HIPPA** 合格的传真或一般电话联络。转诊不需要患者另外提供同意

Financial Policy You agree to pay by credit/debit/Flex/HSA card or cash at the end of your appointment. This practice does not bill insurance/Medicare/Medicaid. Upon request, receipts or itemized bills (2 clinic business days) are available.

- *Upon request, the clinic may email you itemized bill with your treatment and procedure diagnosis even if you may not have secured/HIPPA compliant email.*

*If you **do not want** to receive non-secured email with itemized bill, please sign here* ______________________________

收费政策您同意在会诊完毕后用信用/银行卡，医疗 **Flex/HSA** 卡 或现金付费。此门诊不报保险/公家保险。如果您有需要，我们可以提供收据或详细收费证明（需要两诊所时间）。

- 如果您有需要，即使您没有 **HIPPA** 合格的邮箱，此诊所可能用邮件发给您详细收费证明。

如果您不希望用邮件收收费证明，请在此签名

Medical records are charged at $0.25 per page and will be available only for in person pickup by patients/guardians. Records not from the same business day may require 2 clinic business days to be copied. You may take free pictures of your records in person. Please email ahead to schedule a time.

复印医疗档案每页$0.25 医疗档案只能患者本人或监督人亲自来拿。如果不是同一天的档案，需要两天门诊工作时间。如果提前约时间，您可以自己在门诊免费给您的档案照相。

I agree with the above and acknowledge I have either received a copy of this form and HIPPA privacy notice or have declined. Current copies available online . I may revoke my agreement anytime in writing by mail or email to fang@mecerfamilymed.com

我同意以上协议也收到或放弃收到协议或 HIPPA 隐私公告复印件。您也可以上网看。我可以任何时候写信或邮件要求撤回您的认同

Signature ____________________________________ Print Name if Guardian Signing ______________________
签名 如果是监督人签名，请填姓名