Pennsylvania Union Medical Center
华福诊所
Patient Registration

Today's Date_____

First Name _____MI___ **Last Name _____**中文姓名_____

Address_____

Zip _____City_____ State_____

Phones Home ( ) ___ -_____Cell ( )____-_____Work ( ) _____-_____

Gender: M /F **Date of Birth** ____/_____/_____ **SSN #** _____-_____-_____

Marital Status: Single / Married / Divorced / Widowed Race _____

Employment Status: Employed / Unemployed /Retired / Student

Employer _____ Occupation _____

Email _____

Name of Spouse _____

Who lives at home with you? _____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

Emergency Contact _____ Phone ( ) _____-_____

Who can we release your medical information to? ___Spouse ____Parents

___Emergency Contact ___Other (Please specify)_____

How are you referred to this office? _____

Who is responsible for Medical Bills? Self / Parent /Other_____

Insurance Co. Name _____

Address _____

(on the back of your card)

ID/Policy # _____Copay _____**Group#**_____

Subscriber _____ Relationship _____

Subscriber Date of Birth _____/_____/_____

Do you have other insurance coverage? Yes/No If yes, please specify:

Insurance Co Name _____

Address _____

ID/Policy # _____ Group # _____

AUTHORIZATION ----- PLEASE READ BEFORE SIGNING

To process my medical claims for payment, I hereby authorized Pennsylvania Union Medical Center, or their authorized agents, to release copies of my medical records and/or provided information regarding my physical or mental condition and treatment rendered to my insurance carrier and/or any agent acting on the insurance carrier's behalf. I understand that these records and/or information may include psychiatric/psychotherapy, mental health, HIV, and/or alcohol information or treatment records, and I authorize the release of such records and/or information to my insurance carrier and/or any agent acting on the insurance carrier's behalf.

I also authorize Pennsylvania Union Medical Center to release copies of my medical records to include the above mentioned records and/or information to my primary care, family, or other treating physicians.

I understand that if this is a worker's compensation claim that the insurance carrier may employ a rehabilitation or consulting firm to handle my case. I authorize release of the above mentioned records and/or information to the workmen's compensation insurance and/or rehabilitation or consulting firm.

I hereby assign to Pennsylvania Union Medical Center all payments for medical services rendered to me and/or my dependents, and I understand and agree that any services not covered by my insurance company are my responsibility to pay.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS; HOWEVER, **THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE**. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BUSINESS OFFICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

Name of Policy Holder_____
I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Pennsylvania Union Medical Center for any services furnished me by that party who accepts assignment/Physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical health insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C.3801-3812 provide penalties for withholding this information).

Signature of Patient_____ Date_____

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History Intake Form

Name _____DOB _____Sex _____Date_____

Previous Physician_____Phone Number(___)_____-_____

Past Medical Illness	Hospitalizations/Surgeries: Date: Illness:	Immunizations: Tetanus: Rubella: Hep B: Other:
Current Medical Illness:	Current Medications:	Allergies:

Family History

	Age	Health	Heart Dis	High BP	Cancer	Stroke	Diabetes	Other
Mother								
Father								
Sibling								
Sibling								
Sibling								
Grand parents								

Children

Date of Birth	Gender	Name	Medical Illness

Social History

Employment	Tobacco Use	Caffeine Use
Sexual Preference	Drug Use	Diet
Marital Status	Alcohol Use	Exercise
Immigrant to US since	Education Level	Religion

Acknowledgement of Privacy Practices

By Signing below, I acknowledge that I have been provided with Pennsylvania Union Medical Center's Notice of Information Practice regarding the use and disclosure of my health information for treatment, payment and healthcare operations according to the said notice.

_____	_____
Printed Name of Patient or Legal Representative	Date of Birth
_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Witness Signature	Da