PATIENT INFORMATION FOR MEDICAL RECORDS **病人資料**

PATIENT NAME **姓名**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender **性別:**  Male **男** Female **女**

DATE OF BIRTH **出生日期** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS **住址**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE **家庭電話** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK/ CELL PHONE **工作電話** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS **電郵** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST 4 DIGITs of SOCIAL SECURITY # **工**卡**號碼最後４個數字** \_\_\_\_\_\_\_\_\_\_\_

PRIMARY LANGUAGE: ENGLISH **廣東話** **國語** OTHER **其他**

OCCUPATION **職業** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: S **單身** M  **已婚**

SPOUSES'S NAME **配偶名稱** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE CONTACT NUMBER **配偶聯絡電話 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

WHOM MAY WE THANK FOR REFFERING YOU **轉介醫生** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT PERSON **緊急聯絡人** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP **關係**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER **電話**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS:**

I, the undersigned, assign directly to Dr. Kevin Ho and Golden Gate ENT Corporation, all surgical and medical benefits, if any, otherwise payable to me for services rendered.  I understand that I am financially responsible for all charges whether or not paid by my insurance.   I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

 \_\_\_\_\_\_\_\_\_\_\_\_

 DATE **日期**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE **簽署** PRINT NAME **姓名**