NYU | DENTISTRY

New York University College of Dentistry
345 East 24th Street, New York, NY 10010

PATIENT REGISTRATION FORM
(患者登记表)

Simp.

PATIENT INFORMATION (患者信息):

Name (姓名): _____
Last (姓) First (名) M.I. (中间名缩写)

Gender (性别): ☐ Female (女) ☐ Male (男) ☐ Transgender (变性)
Marital Status (婚姻状况): ☐ Single (单身) ☐ Married (已婚) ☐ Other (其它)

Ethnicity (optional): **(种族 {可选可不选}):**
☐ Black/African American (黑人/ 美国黑人)
☐ Hispanic/Latino (西班牙裔/ 拉丁美洲人)
☐ White/Caucasian (白人/ 高加索裔)
☐ Asian (亚裔)
☐ American Indian or Alaskan Native (美国印第安人或阿拉斯加原住民)
☐ Native Hawaiian or other Pacific Islander (夏威夷原住民或其他太平洋岛住民)

Date of Birth (出生年月日): _____

Social Security Number: _____-_____-_____ **(社会安全号码)**

Address (住址): _____

Occupation (职业): _____

Currently employed? (目前是否就业?) ☐ Yes (是) ☐ No (否)

Highest level of education (最高学历): _____

_____
City (城市) State (州) Zip code (邮编号码)

Phone Numbers (电话号码): _____ _____ _____
Home (家) Work (工作单位) Cell (手机)

Email Address (电子邮件地址): _____

Emergency Contact:
(紧急联系人): _____ _____
Name (姓名) Phone Number (电话号码)

PARENT/GUARDIAN (if patient is a minor) or RESPONSIBLE PARTY (家长 / 监护人 {若患者未成年} 或全权负责者):

Name (姓名): _____
Last (姓) First (名) M.I. (中间名缩写)

Gender (性别): ☐ Female (女) ☐ Male (男) ☐ Transgender (变性)
Marital Status (婚姻状况): ☐ Single (单身) ☐ Married (已婚) ☐ Other (其它)

Date of Birth (出生年月日): _____ **Social Security Number:** _____-_____-_____ **(社会安全号码)**

Address (住址): _____

_____
City (城市) State (州) Zip code (邮编号码)

Phone Numbers (电话号码): _____ _____ _____
Home (家) Work (工作单位) Cell (手机)

INSURANCE OR OTHER 3rd PARTY INFORMATION (保险或其它第三方信息):

☐ Medicaid (医疗补助号码) #_____
☐ Self-Pay/No Insurance (自费 （ 无保险 ））
☐ Private Insurance (私人保险号码) # _____

Name of Plan (保险计划名称): _____

Group # (受保群体号码): _____

Subscriber # (保险第一持有者号码): _____

Social Security #: _____-_____-_____ **(社会安全号码)**

Relationship to Subscriber (与保险第一持有者的关系):
☐ Self (本人) ☐ Spouse (配偶) ☐ Child (孩子) ☐ Other (其他)

Primary Care Provider (主诊医生):
☐ Yes (是) ☐ No (否)

MD/NP Name: _____
(医生 / 高级注册行医护士姓名)

Telephone #: _____
(电话号码)

Insurance Information: _____
(保险信息)

_____

Please indicate how you heard about us (请标明您是如何听说我们的):
☐ Friend or Family (word of mouth) (朋友或家人（相互转告）)
☐ Insurance Plan/Medicaid (保险计划 / 医疗补助)
☐ Private Referral from Dentist (本人牙医推荐)
☐ Screening/Health Fair (体检普查 / 保健活动)
☐ Newspaper/Ad (报纸 / 广告)
☐ Television Ad (电视广告)
☐ Internet (互联网)
☐ Other (其它)