NYU | DENTISTRY

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

PATIENT REGISTRATION FORM
(患者登記表)

Trad.

PATIENT INFORMATION (患者信息):

Name (姓名): _____
Last (姓) First (名) M.I. (中間名縮寫)

Gender (性別): ☐ Female (女) ☐ Male (男) ☐ Transgender (變性)
Marital Status (婚姻狀況): ☐ Single (單身) ☐ Married (已婚) ☐ Other (其它)

Ethnicity (optional): **(種族(可選可不選)):**
☐ Black/African American (黑人/美國黑人)
☐ Hispanic/Latino (西班牙裔/拉丁美洲人)
☐ White/Caucasian (白人/高加索裔)
☐ Asian (亞裔)
☐ American Indian or Alaskan Native (美國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島住民)

Date of Birth (出生年月日): _____

Social Security Number: _____-_____-_____ (社會安全號碼)

Address (住址): _____

Occupation (職業): _____

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

_____
City (城市) State (州) Zip code (郵編號碼)

Highest level of education (最高學歷): _____

Phone Numbers (電話號碼): _____ _____ _____
Home (家) Work (工作單位) Cell (手機)

Email Address (電子郵件地址): _____

Emergency Contact:
(緊急聯繫人): _____ _____
Name (姓名) Phone Number (電話號碼)

PARENT/GUARDIAN (if patient is a minor) or RESPONSIBLE PARTY (家長/ 監護人 {若患者未成年} 或全權負責者):

Name (姓名): _____
Last (姓) First (名) M.I. (中間名縮寫)

Gender (性別): ☐ Female (女) ☐ Male (男) ☐ Transgender (變性)
Marital Status (婚姻狀況): ☐ Single (單身) ☐ Married (已婚) ☐ Other (其它)

Date of Birth (出生年月日): _____ **Social Security Number:** _____-_____-_____ (社會安全號碼)

Address (住址): _____

_____
City (城市) State (州) Zip code (郵編號碼)

Phone Numbers (電話號碼): _____ _____ _____
Home (家) Work (工作單位) Cell (手機)

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

☐ Medicaid (醫療補助號碼) #_____
☐ Self-Pay/No Insurance (自費 (無保險))
☐ Private Insurance (私人保險號碼) # _____

Name of Plan (保險計劃名稱): _____

Group # (受保群體號碼): _____

Subscriber # (保險第一持有者號碼): _____

Social Security #: _____-_____-_____ (社會安全號碼)

Relationship to Subscriber (與保險第一持有者的關係):
☐ Self (本人) ☐ Spouse (配偶) ☐ Child (孩子) ☐ Other (其他)

Primary Care Provider (主診醫生):
☐ Yes (是) ☐ No (否)

MD/NP Name: _____
(醫生 / 高級註冊行醫護士姓名)

Telephone #: _____
(電話號碼)

Insurance Information: _____
(保險信息)

_____

Please indicate how you heard about us (請標明您是如何聽說我們的):
☐ Friend or Family (word of mouth) (朋友或家人 (相互轉告))
☐ Insurance Plan/Medicaid (保險計劃/醫療補助)
☐ Private Referral from Dentist (本人牙醫推薦)
☐ Screening/Health Fair (體檢普查/保健活動)
☐ Newspaper/Ad (報紙/廣告)
☐ Television Ad (電視廣告)
☐ Internet (互聯網)
☐ Other (其它)