Acuiderm 崔建醫學博士
皮膚內外專科皮膚美容專科

James Jian Cui, M.D. Ph.D.
Dermatology & Cosmetic Surgery

Patient Information Form 病人資料表

Insured's Information 受保人資料

(fill out this side only if you are not the primary insurance holder)

Last Name 姓 First Name 名	Last Name 姓 First Name 名
Street & Address 住址	Street & Address 住址
City 城 State 州 Zip 郵區	City 城 State 州 Zip 郵區
Home Phone 住址電話	Home Phone 住址電話
Cell Phone 手機電話	Cell Phone 手機電話
D.O.B Month 月 Day 日 Year 年 出生日期 / /	D.O.B Month 月 Day 日 Year 年 出生日期 / /
Sex 性別: ☐Male 男 ☐ Female 女	Sex 性別: ☐Male 男 ☐ Female 女
Patient's SSN 工卡號碼 - -	Insurer's SSN 工卡號碼 - -
Marital Status 婚姻狀況 ☐ Married 已婚 ☐ Single 未婚 ☐ Other 其他	Relationship 與病人關係 ☐ Spouse 配偶 ☐ Parents 父母 ☐Other 其他
Insurance Name 保險公司名	Insurance Number 保險號碼

Allergy 過敏: ☐ NKA/沒有 ☐ Egg/雞蛋 ☐ Milk/牛奶 ☐ Medication/藥物 ☐ Other/其他

Smoking 抽煙: ☐ Yes/是 ☐No/否 **Alcohol 酗酒:** ☐ Yes/是 ☐ No/否 **Drug Abuse 濫用藥物:** ☐Yes/是 ☐No/否

Ethnicity 種族: ☐ Hispanic/Latino 西班牙裔/拉丁裔 ☐ Not Hispanic or Latino 不是西班牙裔或拉丁裔

Race 種族 ☐ Asian 亞裔 ☐ Black/African American 黑裔/非裔美國人 ☐ White/Caucasian 白人
☐ American Indian/Alaskan Native 美國本土印第安人/阿拉斯加原住民 ☐ Other/其他族裔

Preferred Language 首選語言: ☐ English 英文 ☐ Chinese 中文 ☐ Spanish 西班牙語
☐ Other Language 其他語言:

Emergency Contact Person 緊急聯絡人: Relationship 與病人關係 _____

Contact Name 姓名: Contact No/電話:

Communication Preference 選通訊方式: ☐ Mail 郵件 ☐ Telephone 電話 ☐ Email 郵件
***Email Address 電子郵件地址 :

Past Medical History 過去病史	YES 是	NO 否		YES 是	NO 否
Hypertension 高血壓	☐	☐	Mental Disease 精神病	☐	☐
Heart Disease 心臟病	☐	☐	Stroke 中風	☐	☐
Diabetes 糖尿病	☐	☐	Asthma 哮喘	☐	☐
Gastroenterology Disease 腸胃病	☐	☐	Genitourinary Disease 泌尿	☐	☐
Lung Disease 肺病	☐	☐	Hypercholesterolemia 胆固醇	☐	☐
Blood Disease 血液	☐	☐	Cancer 腫瘤	☐	☐
Liver Disease 肝病	☐	☐	Hospitalization 住院	☐	☐
Surgery 外科手術			Family Medical History 家庭病史		

***PLEASE FLIP OVER AND COMPLETE THE PATIENT CONSENT FORM & HIPAA FORM.**
請**翻閱**後面和**簽**病人同意書及 HIPPA 聯邦私隱慣例表格.

I hereby authorize direct payment of medical benefits to James J. Cui, M.D., for services rendered by James J. Cui., M.D. I understand that I am financially responsible for any balance if my insurance is invalid. 我同意由我受保的保險公司直接支付崔建診所提供服務的醫療費用, 如果我的醫療保險無效時, 我願意負責結清給崔建診所的診金和治療費用.

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration 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 be used in place of the original, and request payment of medical 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.1128B of the Social Security Act and 31 U.S.C. 3801-3802 providers penalties for withholding this information.)

Print Name of Patient or Legal Guardian/病人或病人代表的名字正楷	**Relationship to Patient/與病人關係**
Signature of Patient or Legal Guardian/病人或病人代表的簽名 **X**	**Date/日期**

PATIENT CONSENT FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
HIPAA"聯邦健康保險流通與責任法案"的私隱慣例表格

With my consent, Dr. James J. Cui, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare options (TPO). Please refer to Dr. James J. Cui, M.D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dr. James J. Cui, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. James J. Cui, M.D.'s privacy officer at 136-20 38th Avenue Suite 5H Flushing NY 11354, 185 Canal Street Suite 201 New York NY 10013, or 6402 8th Avenue Suite 505 Brooklyn NY 11220 offices.

With my consent, Dr. James J. Cui, M.D. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dr. James J. Cui, M.D.'s uses and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. James J. Cui, M.D. may decline to provide treatment to me.

在您簽署此同意書前, 您有權閱讀本醫務所的醫療資料保密通知書. 醫療資料保密通知書麗, 給予您的某些權利 (說明您身爲病人在法律下所應有的權利), 以及我們對醫療資料所做之保密和維護的守則.此醫療資料保密通知書的內容, 也許日後因需要會有所更改, 屆時您可以與本醫務所聯絡要求索取一份紙板複印.

您簽這份同意書,是同意本醫務所如何運用和透露您的醫療資料來爲您醫療, 爲領取醫療費和提升醫療服務. 在醫療程序, 領取醫療費和執行健康照顧方面, 病人有權限制本醫務所如何運用或透露病人的醫療資料, 但本醫務所並不需要贊同病人所提出的限制. 您有權在任何期間, 以親自簽署的書信來取消此同意書, 接到取消信書後, 本醫務所將停止運用或透露病人的醫療資料. 但是, 這並不影響本醫務所在收到您正式書面取消信之前, 根據醫療程序只需要和您原先同意的情況下, 對您的健康資料所做的運用和透露.

本醫務所可以要求病人簽此同意書後才開始爲病人進行醫療的程序.

Print Name of Patient or Legal Guardian/病人或病人代表的名字正楷	**Relationship to Patient/與病人關係**
Signature of Patient or Legal Guardian/病人或病人代表的簽名 **X**	**Date/日期**