

Patient Registration Form

(Under 18 years old / 18岁以下)

Please PRINT clearly using blue or black ink. Include photocopy of passport.

请使用蓝色或黑色水笔端正填写此表，并请随表附上护照复印件。

MRN

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Minor's Information 未成年病人资料

Last Name 姓		First Name 名		Middle	
Date Of Birth 出生日期		Gender 性别	<input type="checkbox"/> M 男 <input type="checkbox"/> F 女	Chinese Name 中文名	
(YYYY/MM/DD年/月/日)					
Nationality 国籍		Passport No. 护照号码			

Parent / Legal Guardian's Information 父母/法定监护人资料

Last Name 姓		First Name 名		Middle	
Relationship to Patient 与病人关系		Chinese Name 中文名			
Local Address 本地住址					
City 城市		Postal Code 邮编		Pudong 浦东 <input type="checkbox"/> Puxi 浦西 <input type="checkbox"/>	District 地区
Daytime Phone 白天电话		Evening Phone 夜间电话			
Mobile Phone 移动电话		E-mail 电子邮件			
Company 公司		Occupation 职业			

Method Of Payment 付款方式

<input type="checkbox"/> Cash 现金	<input type="checkbox"/> Credit Card 信用卡	<input type="checkbox"/> Company 公司	<input type="checkbox"/> Insurance 保险
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General Consent 同意书

I certify that I am the parent / legal guardian of and authorized to represent the above named minor. I voluntarily request and consent to medical services for the above named minor, including examinations, diagnostic tests, treatments, procedures, immunizations, hospitalizations, etc., deemed advisable by the professional staff of Shanghai East International Medical Center (SEIMC). I understand and agree that each medical service provided will incur a separate and additional charge, and that I am responsible for payment in full of all charges for medical services performed.

Should SEIMC provide direct billing to an insurance company, I understand and agree that I must complete a credit card authorization form and pay up-front for any deductibles, co-payments, and uncovered services. I authorize the release to the insurance company of any medical records or other personal information as may be required to determine benefits and secure payment of claims. I authorize SEIMC to charge my credit card for any amounts not reimbursed by the insurance company.

I acknowledge I have read this consent and understand its contents. I also understand that any questions I have may be discussed with SEIMC.

我保证我是此未成年人的家长/法定监护人，并有权代表他/她。我自愿要求并同意该未成年人进行东方联合医院专职医护人员所建议的诊疗措施，如检查、诊断性测试、治疗、手术、免疫接种、住院等。我了解并同意东方联合医院会对这些诊疗服务收取额外的、相应的费用，而我也负有义务支付诊疗过程中所产生的一切费用。

如果东方联合医院需要直接和保险公司结单，我了解并同意完整地填写信用卡授权表格，并将提前支付一切免赔额，共同支付款以及保险公司不予理赔的医疗服务费用。我授权东方联合医院将我的医疗记录以及其他个人信息告知保险公司以确定保险金额和保证理赔的顺利进行。我同时也授权东方联合医院使用我的信用卡支付任何保险公司不予理赔的款项。

我已阅读并已理解了这份同意书的内容。我也了解如果我有任意的任何问题都可以和东方联合医院进行讨论。

Parent / Legal Guardian's Signature 父母/法定监护人签名	Date 日期 (YYYY/MM/DD年/月/日)

Please assist us by completing the following questions 请协助我们完成以下问题

<input type="checkbox"/> I am currently living/working in Shanghai. 我目前在上海居住/工作。	
<input type="checkbox"/> I am living outside of Shanghai. Please specify	我不住在上海，请详细说明
<input type="checkbox"/> I am in Shanghai as a tourist/traveler. 我是来上海旅游的。	

Nationality: 国籍:

I found out about SEIMC by: 我通过以下途径知道上海东方联合医院:

<input type="checkbox"/> Magazine 杂志	<input type="checkbox"/> Community Event 社区活动	<input type="checkbox"/> Internet/Web 网络	<input type="checkbox"/> Friend/Relative 朋友/亲戚
<input type="checkbox"/> Employer 老板/雇主	<input type="checkbox"/> Insurance Company 保险公司	<input type="checkbox"/> Hotel 酒店/宾馆	<input type="checkbox"/> Relocation Agent 移居中介

I wish to receive health information from SEIMC. 我愿意接收来自上海东方联合医院的健康信息。

My E-mail address: 我的电子邮箱: