Patient Registration Form

(18 years old and over / 18岁及以上)

Shanghai East International Medical Center

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，并请随表附上护照影印件。

MRN

Patient's Information 病人资料

Last Name 姓 | First Name 名 | Middle

Date Of Birth 出生日期 (YYYY/MM/DD年/月/日) | Gender 性别 ☐ M 男 ☐ F 女 | Chinese Name 中文名

Nationality 国籍 | Passport No. 护照号码 | Marital Status 婚姻状况

Local Address 本地住址

City 城市 | Postal Code 邮编 | ☐ Pudong浦东 ☐ Puxi 浦西 | 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

Emergency Contact 紧急情况联系人

Name 姓名 | Relationship 与病人关系

Phone 联系电话 | Other Phone 其它联系电话

Method Of Payment 付款方式

☐ Cash 现金 ☐ Credit Card 信用卡 ☐ Company公司_____ ☐ Insurance 保险_____

General Consent 同意书

I voluntarily request and consent to medical services, 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.

我自愿要求并同意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何的问题都可以和东方联合医院进行讨论。

Patient's Signature 病人签名 | 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

☐ I am currently living/working in Shanghai. 我目前在上海居住/工作。

☐ I am living outside of Shanghai. Please specify | 我不住在上海，请详细说明

☐ 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:

☐ Magazine 杂志 ☐ Community Event 社区活动 ☐ Internet/Web 网络 ☐ Friend/Relative 朋友/亲戚

☐ Employer 老板/雇主 ☐ Insurance Company 保险公司 ☐ Hotel 酒店/宾馆 ☐ 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: