



Registration

* Name / 姓名 (Last姓/Middle中/First名)

* Mandatory Field / *为必填项

* Gender / 性别: 男 Male 女 Female * DOB / 出生日期: _____ Y年 _____ M月 _____ D日

* Identity Card No. / 证件号码: _____ * Nationality / 国籍: _____

Marital Status / 婚姻状况: Single 单身 Married 已婚 Other 其它 * Language / 语言: _____

* E-mail / 邮箱地址: _____ * Mobile No. / 手机: _____

Daytime Phone / 白天电话: _____ Evening Phone / 夜间电话: _____

Company / 公司名称: _____ Occupation / 职业: _____

Address / 地址: _____ City / 城市: _____ Postal Code / 邮编: _____

Emergency Contact Name / 紧急情况下联系人: _____

Emergency Contact No. / 电话: _____ Relationship / 关系: _____

Insurance? 参加保险? Yes 是 NO 否 Policy/Group No. / 保险类型: _____

Insurance Company / 保险公司名称: _____ Insurance ID No. / 保险号码: _____

General Consent 同意书

- I voluntarily request and consent to medical services deemed advisable by the professional staff of WorldPath Clinic International (WPCI). 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 WPCI provide direct billing to an insurance company, I understand and agree that I must obtain authorization and pay up-front for any deductibles, co-payments, and uncovered services. I authorize the release to the insurance company and its agents of any medical records or other personal information as may be required to determine benefits and secure payment of claims.
- I hereby authorize WPCI to maintain my medical records. Photocopy of medical record can be obtained in person with my permission and proof of photo ID.
- I understand that I am financially responsible for the services received including any outstanding balance not covered by insurance company.
- 我了解并同意执行上海沃德医疗中心医护人员所建议的诊疗措施，并有义务支付诊疗过程中所产生的一切费用。
- 如果需要直接和保险公司结算，我同意填写授权表格，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。
- 我同意并授权上海沃德医疗中心将我的病史资料以及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。
- 我的病史资料由上海沃德医疗中心负责妥善保管，如需复印，由我本人在出示有效证件后获取。
- 我了解我有义务支付保险公司不予理赔的未清费用。

* How did you learn about WorldPath Clinic International? 您是怎样了解到我们上海沃德医疗中心的?

Friend/Relative 朋友 Magazine 杂志 : _____ Insurance Company 保险公司: _____

Internet/ Web 网站: _____ Others: _____

Signature 签名: _____ Date 日期: _____ Y年 _____ M月 _____ D日



MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____

Social Security # _____ Referring Physician _____

History of Present Illness

Please explain your current problem. Include location of problem, how long you have experienced this problem, and the severity of the problem. Include what makes the problem worse or better and any associated signs or symptoms.

Past History

List any medications you presently take: _____

List all illness/injuries/surgeries you have had that required hospitalization: _____

Do you have allergies to any medications? YES NO

If yes, list medications you are allergic to: _____

Are you allergic to Latex? YES NO

Family History

Disease	Family Member		Disease	Family Member

Social History

Current Occupation _____

Do You Drive? YES NO

Do You Drink Alcohol? YES NO If yes, how often? _____

Do You Smoke/Chew Tobacco? YES NO If yes, how much a day? _____

Do You Do Drugs? YES NO If yes, what kind? _____



Review of Systems (Please check box if Yes)

Patient Name: _____

General	Gastrointestinal	Genitourinary
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Dysphagia (problems swallowing)	<input type="checkbox"/> Urinary Infections
<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Menopause
<input type="checkbox"/> Bleeding		
<input type="checkbox"/> Lumps or Masses	Cardiovascular	Neurologic
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Heart DX/Pain	<input type="checkbox"/> Seizures
<input type="checkbox"/> Itching/Rash	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Numbness
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> Weakness
<input type="checkbox"/> Cancer		
Ear-Eyes-Nose-Throat	Respiratory	Musculoskeletal
<input type="checkbox"/> Visual Change	<input type="checkbox"/> Cough/Sputum	<input type="checkbox"/> Backache
<input type="checkbox"/> Hearing Change	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Tinnitus (ringing in ears)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Joint Swelling
<input type="checkbox"/> Dentures	<input type="checkbox"/> Pleurisy/Pneumonia	
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Shortness of Breath	Skin
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bruises Easily
<input type="checkbox"/> Sneezing		<input type="checkbox"/> Sores
		<input type="checkbox"/> Rashes/Lesions
Breast		
<input type="checkbox"/> Lumps, Pain, Nipple Discharge		

Explain all "YES" answers here:

***OFFICE USE ONLY**

Physician Signature _____

Date Physician Reviewed _____

Above History Updated (initial and date all changes to above information):

Date	Physician Signature	Date	Physician Signature



Patient Name: _____

Please answer, yes or no, to the following questions as they pertain to pre-authorization for anti-inflammatory therapy.

1. Have you required Nonsteroidal anti-inflammatory therapy for more than 21 consecutive days?
 YES NO

2. Have you experienced intolerance with at least 2 other anti-inflammatory medications? (i.e. Motrin, Aleve, Advil, Naprosyn, etc.)
 YES NO

3. Do you have a history of peptic ulcer disease, Nonsteroidal anti-inflammatory related ulcer, GI bleed, or coagulation defect?
 YES NO

4. Are you receiving drug therapy with corticosteroids, anticoagulants, antiplatelets, or methotrexate?
 YES NO

5. Are you currently receiving an H2 antagonist, proton pump inhibitor, or misoprotol (cytotec)? (i.e. Prevacid, Zantac, Prilosec, etc)
 YES NO