Ted Shen M.D., Inc.
301 S. Fair Oaks Ave
Suite 406
Pasadena, CA 91105
Phone (626) 737-6200

225 S. First Ave
Suite 201
Arcadia, CA 91006
Fax (626) 737-6202

Date (填表日期): _____

Patient Name (姓名):_____ _____
LAST (姓) FIRST (名) MIDDLE (中間名) Nickname (昵称)

Address (地址): _____
STREET & APT # (號碼/路/街) CITY (城市) STATE (州) ZIP (區域號碼)

Home Ph# (家用電話號碼) : _____ Mobile Ph# (手機號碼) : _____

Any restrictions for contacting you? (是否有不方便聯絡的時間?) ❑ No ❑Yes: _____

May we leave detailed messages on your voicemail or answering machine? ❑No ❑ Yes
(是否可以留重要訊息在您的電話語音系統或答錄機?)

Birthdate (生日): ____/____/____ Primary Language (語): _____ Sex (性别): ❑ Male (男) ❑ Female (女)

Email (電子信箱): _____

SSN (社會安全號碼): _____ Race (人種): _____

Marital Status (婚姻狀況): ❑ Single (單身) ❑ Married (已婚與配偶姓名) ❑ Other (其他): _____

Primary Care Physician (家庭医生) : _____

Emergency Contact (緊急聯絡人) : _____ Relationship (關係) : _____

Home # (家用電話號碼) : _____ Mobile # (手機號碼) : _____

Preferred Pharmacy Name (首选药房名称): _____ Pharmacy Phone # (药房电话号码): _____

Pharmacy Address (药房地址): _____

Pharmacy Phone # (药房电话号码): _____

I hereby authorize direct payment of surgical/medical benefits to Ted Shen M.D., Inc. for services rendered by Dr. Shen or persons under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.
I hereby authorize Ted Shen M.D., Inc. to release any medical/incidental information that may be necessary for medical care or in the processing of applications for financial benefit.
I certify that all the information given by me in applying for payment is correct. I authorize release of all records upon request. I request that payment of authorized benefits be made on my behalf.
I understand that office visit charges are payable on the day service is rendered. I authorize Ted Shen M.D., Inc. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. If my balance is not paid within 120 days of service date, it will be sent to collections and a 15% fee will be added to the total.

I hereby acknowledge that I have been presented with a copy the Notice of Privacy Practices of Ted Shen M.D., Inc 225 S. First Ave #201 Arcadia, CA 91006; Fax: 626.737-6202.

Signature (簽名): _____ Date (日期): _____

Name (if Signed By Parent/Guardian) (代理人簽名): _____

Patient Questionnaire

Patient Name (姓名): _____ Today's Date (填表日期): _____

Birthdate (生日): _____

Allergies: List all medications and foods as well as reaction to them
过敏: 列出所有药物和食物以及对它们的反应 ❑ No Known Allergies (没有已知的过敏症)

_____ _____ _____

_____ _____ _____

Medications: List current medications and dosage if possible
药方: 列出当前的药物 ❑ None (无)

_____ _____ _____

_____ _____ _____

Past medical history: List all medical condition
既往病史: 列出所有医疗状况 ❑ None (无)

_____ _____ _____

_____ _____ _____

Past Surgical History: List all prior surgeries
既往手术史: 列出所有先前的手术 ❑ None (无)

_____ _____ _____

_____ _____ _____

Family History: Pleases list medical conditions of blood relatives
家族病史: 列出亲属的所有医疗状况 ❑ None (无)

_____ _____ _____

_____ _____ _____

Social History (社会史)

***Tobacco Usage* (烟草使用):**
❑ Never Smoker (从不吸烟)
❑ Current Someday Smoker (偶尔吸烟者)
❑ Current Every day Smoker (目前每天吸烟者)
❑ Vape Smoker (电子烟吸烟者)
❑ Former Smoker (曾经抽烟)

***Alcohol Usage* (酒精的使用):**
❑ None (无)
❑ Occasional (偶尔)
❑ Social (社交场合)
❑ Daily 1-2 drinks (每日一到两杯)
❑ Daily 2-5 drinks (每天喝两到五杯)
❑ Daily >5 drinks (每日饮酒五杯以上)
❑ Daily Alcoholic (每日饮酒)

***Recreational Drug Usage* (娱乐性药物的使用):**
❑ None (毫无)
❑ Marijuana (大麻)
❑ Other (其它): _____

Have you experienced any falls or problems with balance in the last year?
(去年您是否经历过跌倒或平衡问题？) ❑YES ❑NO

Height (身高) _____ft Weight (体重) _____