

# Danny Fong, MD, P.C.

Plastic & Reconstructive Surgery  
Hand Surgery

Patient Information 病人資料

Date: \_\_\_\_\_

**Patient's Full name:** \_\_\_\_\_

病人姓名: \_\_\_\_\_

**Age:** \_\_\_\_\_

年齡 \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

出生日期 M 月/ D 日/ Y 年

**Social Security#:** \_\_\_\_\_

公卡號碼 \_\_\_\_\_

**Sex: M/F**

性別 男/女

**Marital/Family Status:**

已婚 M/ 未婚 S \_\_\_\_\_

**Address:**

住址 \_\_\_\_\_

**Home/Cell Phone:**

住址電話/手機 \_\_\_\_\_

**Email:** \_\_\_\_\_

STREET APT

CITY STATE ZIP CODE

**Current Occupation:** \_\_\_\_\_

職業

**Employer:** \_\_\_\_\_

僱主

If Student, Name of School/College: \_\_\_\_\_

如果是學生, 校名

City: \_\_\_\_\_ State: \_\_\_\_\_ FT/ PT: \_\_\_\_\_

城市

州

全天/半天

**Spouse's/Parent's name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

配偶/家長姓名

**Phone Number** 電話: \_\_\_\_\_

**Emergency Contact (required):** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

緊急連絡人

FIRST NAME LAST NAME

關係

**Phone Number** 電話: \_\_\_\_\_

**Primary Doctor:** \_\_\_\_\_ **Referred By:** \_\_\_\_\_

家庭醫生

FIRST NAME

LAST NAME

介紹人

FIRST NAME

LAST NAME

**Has this office treated other member(s) of your family before: Yes \_\_\_ No \_\_\_**

**Name:** \_\_\_\_\_ **可有家庭成員曾經看過鄭立中**

Bill will be paid by: Self \_\_\_\_\_ Insurance \_\_\_\_\_ Other \_\_\_\_\_

付款人

自己

保險

其它

**Primary Insurer:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

保險會員姓名

和病人的關係

**Date of Birth:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

出生日期

電話

**Social Security #:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

工卡號碼

保險卡號碼

**Please complete and sign the back of form** ⇨

请填写并在表格背面签名

**PAST MEDICAL HISTORY 病歷**

Please list all major surgeries, illnesses, and injuries: 請寫下所有手術, 痛症及損傷

**MEDICATIONS CURRENTLY TAKEN 現在服用的藥物**

**HEALTH QUESTIONS 健康資料**

Yes\_\_ No\_\_ Are you allergic to any drugs or medications? 有沒有對任何藥物感 If yes, to what medication and describe the reaction: 如果有對任何藥物敏感, 請寫下藥名和反應

Yes\_\_ No\_\_ Have you ever had a bad reaction to General Anesthesia? 有沒有對全身麻醉敏感

Yes\_\_ No\_\_ Have you ever had a bad reaction to Local Anesthesia? 有沒有對局部麻醉敏感

Yes\_\_ No\_\_ Do you have high blood pressure? 有沒有高血壓

Yes\_\_ No\_\_ Do you have diabetes? 有沒有糖尿病

Yes\_\_ No\_\_ Do you have any heart condition? 有沒有心臟病

Yes\_\_ No\_\_ Do you bleed unusually easily from cuts or surgery? 不小心割傷會不會流血不止

Yes\_\_ No\_\_ Do you form large scars or keloids? 身上有沒有大疤痕或肉瘤

Yes\_\_ No\_\_ Do you smoke? 有沒有抽煙

Yes\_\_ No\_\_ Do you consume alcohol regularly? 有沒有喝酒

Yes\_\_ No\_\_ Is your visit related to an injury at work or an auto accident? 這次應診的病症是不是因工作受傷或車禍

**Height** 高度 \_\_\_\_\_

**Weight** 重量 \_\_\_\_\_

When was your last physical examination? Date: \_\_\_\_\_ 最近身體檢查的日期

Briefly explain the reason for today's visit. 今天應診的原因

Have you seen another plastic surgeon about the condition that brings you here?

Yes\_\_ No\_\_ Comments:

**I hereby authorize payment to be made directly to Danny Fong, M.D. for any medical or surgical benefits that he may be entitled to under my Medical-Surgical plans. I understand that I am responsible for any balance due for my professional services in excess of the benefits provided by my insurance policy.**

X \_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Witness Signature  
(OFFICE USE ONLY)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date