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Preferred	[Home Phone]			[Work Phone]			[Cell Phone]			
仕音安全號碼	()			()				()			
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財務責任方 [Financially Responsible Party] 患者本人是否為責任方 [#g人? 『是 『杏(若您年滿 18 歳且 並未接受機構的照顧,則屬證保人,及須負責繳納款診期間自身可能産生的任何費用的財務責任方 [Is patient responsible party/guarantor? 『Yes 『No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)] 姓名						1			1		
農者本人是否為責任方/ 簿保人? □是 □否(若您年滿 18 歳日並未接受機構的照顧,則關總保人,及須負責繳納飲診期間自身可能產生的任何費用的別務責任方) [Is patient responsible party/guarantor? □ Yes □ No(If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)] 姓名 [Name] 地址 [Address] 城市 / 州、新蓮區號 [City/State/Zip] 與患者的關係 [Relationship to Patient] 能業 [Occupation] 工作電話 [Home Phone] (Cell Phone] (Cell Phone] □首選 [Preferred] Preferred] 姓名 [Name] 東書 的關係 [Relationship to Patient] 「中ferred] 東京 古道選 [Preferred] 東京 古河道 [Physician Phone/Fax (if known)] [Physician Address]	-							[Country of C	originj		
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	(°C1)1				
	[Physician Phone/Fax (if known)]				
醫師地址					
[Physician Address]					
主要保險公司					
[Primary Insurance Company]					
□ EYEMED □ MEDICARE □ SPECTERA □ VSP □ MARCH					
□ DAVIS VISION □ MEDICAID □ BLOCK □ NVA □ SUPERIOR					
□ EMBLEM HEALTH □ HUMANA □ CIGNA □ EMPIRE BCBS □ OTHER					
保單號碼組別號碼					
[Policy #] [Group #]	[Group #]				
患者與受保人的關係 投保人姓名(若非患者本人)					
[Patient's Relationship to Insured] [Name of Subscriber (if other than patient)]	[Name of Subscriber (if other than patient)]				
□本人 □配偶 □子女					
[Self] [Spouse] [Child]					
□ 其他 [Other]					
投保人社會安全號碼 性別 出生日期 投保人的僱主 工作電話					
[Subscriber's Social Security #] [Gender] [Date of Birth] [Employer of Subscriber] [Work Phone]					
□ 男 [M] ()					
□女 [F]					
備選保險公司 保單號碼 組別號碼					
[Secondary Insurance Company] [Policy #] [Group #]					
患者與受保人的關係 投保人姓名(若非患者本人)	投保人姓名 (若非患者本人)				
[Patient's Relationship to Insured] [Name of Subscriber (if other than patient)]					
□本人 □配偶 □子女					
[Self] [Spouse] [Child]					
□ 其他 [Other]					
投保人社會安全號碼 性別 出生日期 投保人的僱主 工作電話					
[Subscriber's Social Security #] [Gender] [Date of Birth] [Employer of Subscriber] [Work Phone]					
□ 男 [M] ()					
□女 [F]					
在下方簽名,表示我確認盡我所能提供的資訊乃屬正確無誤。					
[By signing below, I acknowledge that the information I provided is correct to the best of my ability.] 患者簽名					
	日期:年月日				
[Date]					
Y					
格保人簽名(若非患者本人):					
[Guarantor Signature (if other than patient)] 日期:年月日	日期: 年 月 日				
[Date]					
X					