UNIVERSITY OF THE PACIFIC

Hearing and Balance Center

# 太平洋大学

## 听力与平衡中心

# 登记表

## (Intake Form)

患者姓名 _____ 出生日期 _____

(Patient Name) 职位 (Title) 名字 (First) 姓氏 (Last) 中间名字字首 (MI) (Date of Birth)

地址 _____

(Address) 街道 (Street) 城市 (City) 州 (State) 邮编 (Zip)

家庭电话 _____ 手机 _____

(Home Phone) ☐ 若此电话不想接受留言，请勾选 (Cellphone) ☐ 若此电话不想接受留言，请勾选

(check if you do not want voicemail messages left on this number) (check if you do not want voicemail messages left on this number)

电子邮件 _____ 性别 ☐ 男 ☐ 女 习惯语言 _____

(Email) (Sex:) (M) (F) (Preferred Language)

紧急联系人 _____ 电话 _____

(Emergency Contact) (Phone)

主保健医生 _____ 电话 _____

(Primary Care Physician) (Phone)

耳鼻喉科医生 _____ 电话 _____

(Otolaryngologist/ENT (if applicable)) (Phone)

**您通过何种方式了解到我们? (How did you find out about us?)**

☐ Yelp ☐ 雇主 (Employer) ☐ 讲座 (Consumer Seminar) ☐ 患者推荐 _____ (Recommended by Patient)

☐ 脸书 (Facebook) ☐ 保险 (Insurance) ☐ 医师推荐 _____ (Referred by Physician)

☐ 网络搜索 (Internet Search) ☐ 广告 (Advertisement) ☐ 其他 _____ (Other)

**勾选方框并在下面签名 (Check the boxes and sign below)**

☐ 本人同意，本人将最终就所提供的服务对账户中的余额负责。

(I understand that I am responsible for all financial balances resulting from service or product received that is not paid by my insurance or any third-party payer.)

☐ 本人同意在此守则下，向本人的保险公司、医疗服务提供者、受让人及/或受益人及所有其他相关人士公布本人的医疗记录及其他相关资料，包括口头及书面资料。无患者标识的信息可能用于质量控制的目的。

(I give permission to this practice to release information, verbal and written, contained in my medical record and other related information to my insurance company, healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.)

☐ 本人同意接收关于诊所服务及产品活动预告、降价及文章有关的信息。

(I give permission to receive information about upcoming events, specials and articles pertaining to services or products in the clinic.)

☐ 本人明白太平洋大学开展研究是为了进一步促进听力学领域发展并促进患者康复。本人准许太平洋大学就未来研究与本人联系。

(I understand that the University of the Pacific conducts research to further the field of audiology and improve patient outcomes. I give permission for the University of the Pacific to contact me regarding future studies.)

## 大学诊所信息公开

(**University Clinic Disclosure**)

- **临床服务由临床小组提供。每个小组由临床教员/导师、研究生临床医生和其他所需咨询教员组成。**
  **(Clinical services are provided by clinical teams. Each team is composed of a clinical faculty/instructor, graduate student clinicians and another consultative faculty as needed.)**
  - » 所有临床教授/导师均持有有效加州执照，且均为经验丰富的听力师。临床教授/导师直接负责患者护理和监督。
    (All clinical faculty/instructors have a valid CA license and are experienced audiologists. Clinical faculty/instructors are directly responsible for patient care and supervision.)
- 研究生临床医生可出于教育目的观察和协助患者预约。
  (Graduate student clinicians may observe and assist in patient appointments for educational purposes.)
- 可通过可视化和/或电子手段进行观察和/或供学生临床医生和临床教员/导师在制定诊断/治疗计划时使用的录音和录像观察服务。录音录像可用于课堂教学。尊重所有信息的机密性并遵循HIPAA法案指导。
  (Services may be observed by visual and/or electronic means and/or audio and video recorded to be used by the student clinician and clinical faculty/instructor in the development of diagnostic/treatment plans. Audio/video recordings may be used for educational purposes in the classroom. Confidentiality of all information will be honored, and HIPAA guidelines followed.)

本人已详阅本表格所填之所有资料，并同意上述勾选项，保证所填资料尽本人所知真实无误，并同意接受本诊所的治疗。

(I have read all the information on this form, agree with the checked boxes above, certify that this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.)

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|---|---|
| 患者签字<br>(Patient Signature) | 日期<br>(Date) |
| 法定监护人（若患者为未成年人）<br>(Legal Guardian if Patient is a Minor) | 日期<br>(Date) |