# Yin,Xuebin, M.D
# 尹雪彬医生
# WELCOME

## Personal Information个人资料

Name姓名: _____.
DOB出生日期:_____. SS#工卡号: _____._____
Home Address家庭住址: _____.
_____.
Home Phone住宅电话: _____.
Work Phone工作电话: _____.
Cell Phone 手提电话: _____.

## Status婚姻状况

**[**Single未婚**]** **[**Married已婚**]** **[**Divorced离异**]** **[**Widowed丧偶**]**

## Insurance Information医疗保险

Insurance Name保险名称: _____.
Insurance ID#保险号: _____.
Insured's Name保险人姓名: _____.
Relation与保险人关系: _____._____
Insured's DOB保险人出生日期: _____.
Insured's SS#保险人工卡号: _____._____

## In Event of Emergency若有紧急情况，您的联系人是

Name姓名: _____.
Relation与您的关系: _____.
Home Phone住宅电话: _____.
Cell Phone 手提电话: _____.
Family Doctor家庭医生: _____.
Family Doctor's Phone家庭医生电话: _____._

_____.I hereby authorize assignment of my insurance Rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

我授权我的保险公司支付给医生为我所提供的诊断 和治疗费用.我理解在必要的情况下, 我必须支付给医生保险公司未付完的余额。