Commonwealth Healthcare Corporation

COMMONWEALTH HEALTH CENTER

PATIENT REGISTRATION

*여권과 동일,영문으로 작성요망

Office Use Only - **CHC Chart #:** _____

Name: 성 _____ (Last Name) 이름 _____ (First Name) _____ (Middle Name)

Date of Birth: 생년월일 (월/일/연도) _____ (Month Day Year) **Place of Birth:** 출생도시 _____ (City) _____ (State) **Gender:** 성별 ☐ Male 남 ☐ Female 여

Social Security No.: 주민등록번호 _____ **EMAIL:** 이메일 주소 _____

Marital Status: (*Please Check Box*) 결혼여부 ☐ 미혼 Single ☐ 결혼 Married ☐ 이혼 Divorced ☐ 별거 Separated ☐ 사별 Widow **Religion:** 종교(무교일경우:NONE) _____

Address (P.O. Box): 현거주지 주소(한국주소와 역순으로 뒤에서부터 표기) **Street Address:** _____

City: _____ **State:** _____ **Zip Code:** 우편번호 _____ **Village:** _____

Home Phone #: ( ) 집 전화번호 _____ **Cell Phone #:** ( ) 핸드폰번호 (+82-10-****-****) _____

Employer: 직장명(무직일경우:NONE) _____ **Work Phone:** ( ) 직장전화번호 _____

ETHNICITY BACKGROUND (*Please Circle*):

Bangladesh Carolinian Chamorro Chinese Caucasian Ponapean Palauan Yapese
Filipino Japanese Korean Nepal Chuukese Hispanic Other: _____

PARENTS - (*If patient below 17 years old and younger*)

Mother's Name: _____ (Maiden Name First Name Middle Name) **Employer:** _____ **Contact No.:** _____

Father's Full Name: _____ **Employer:** _____ **Contact No.:** _____

CLASSIFICATION: (Please Check Mark)

_____ **U.S. CITIZEN BORN IN CNMI** _____ **U.S. CITIZEN BORN OUTSIDE CNMI** _____ **U.S/CNMI RESIDENT** _____ **MICRONESIAN** _____ **BUSINESS PERMIT**
_____ **OTHERS** _____

_____ **NON-RESIDENT** (Contract Worker): Passport No.: _____ Exp. Date: _____

Receipt CW No.: _____ Exp. Date: _____ Other Info: _____

_____ **DEPENDENT OF NON-RESIDENT** (Contract Worker): Passport No.: _____ Exp. Date: _____

VISA Control No.: _____ Exp. Date: _____ Status: _____

_____ **TOURIST:** Passport No.: 여권번호 _____ Exp. Date: 여권만료일(일/월/년도) _____

Name of Hotel: 호텔이름 _____ Room No.: 방번호 _____

EMERGENCY CONTACT INFORMATION 보호자 정보

Name: 성 _____ (Last Name) / 이름 _____ (First Name) / _____ (Middle Name) **Relationship to Patient:** 관계 _____

Address (P.O. Box): 현거주지 주소(한국주소와 역순으로 뒤에서부터 표기) _____

City: _____ **State:** _____ **Zip Code:** _____ **Village:** _____ **Phone No. :** ( ) 연락가능한 전화번호 _____

NEXT OF KIN

Name: _____ (Last Name) / _____ (First Name) / _____ (Middle Name) **Relationship to Patient:** _____

Address (P.O. Box): _____

City: _____ **State:** _____ **Zip Code:** _____ **Village:** _____ **Phone No. :** ( ) _____

PRIMARY INSURANCE

Insurance Company: _____ Effective Date: _____

Subscriber: _____ Coverage: _____

Policy No.: _____ Group Number (if any): _____

SECONDARY INSURANCE

Insurance Company: _____ Effective Date: _____

Subscriber: _____ Coverage: _____

Policy No.: _____ Group Number (if any): _____

THE ABOVE STATEMENT ARE TRUE AND TO THE BEST OF MY KNOWLEDGE

PATIENT'S SIGNATURE: 서명 _____ **DATE:** 작성날짜 (일/월/연도) _____