기독의료상조회
CHRISTIAN MUTUAL MED-AID
Since 1996
Owned by Logos Missions, Inc.

Well-Being Care Processing
건강검진용

① Personal Information

Member/Patient Information 회원/환자 정보 **MEMB #** 회원번호	Full Name (회원/환자 이름)	Date of Birth (생년월일)	Gender (성별) ☐ Male (남) ☐ Female (여)
	Street Address (주소) Apt./Uni. #(호) City (시) State (주) Zip Code (우편번호)		
	Primary Contact Phone (☐Cell ☐Home ☐Work)	Secondary Contact Phone (☐Cell ☐Home ☐Work)	E-mail (이메일)

② Member Qualification Questions

Christian Testimony 신앙고백	☐ Yes 예 ☐ No 아니오	Do you believe that Jesus Christ is your Lord and Savior? 당신은 예수 그리스도가 당신의 구세주이심을 믿습니까?
Healthy Lifestyle 건강한 생활 습관	☐ Yes 예 ☐ No 아니오	Have you smoked cigarettes in the last 12 months? 지난 12 개월동안 흡연기록이 있으십니까?
	☐ Yes 예 ☐ No 아니오	Do you currently drink alcohol? 당신은 음주를 합니까?

③ Medical Bill(s): Please attach the itemized bill(s) and proof of payment (자세한 진료비 내역서 및 영수증을 첨부하여 주십시오.)

	Date of Service 서비스 일자	Medical Provider 의료기관	Reason for Visit 방문이유	Original Amount 의료비 원금	Discount Amount 할인액	Paid Amount 지불액
1	MM/DD/YYYY					
2	MM/DD/YYYY					
3	MM/DD/YYYY					
4	MM/DD/YYYY					
5	MM/DD/YYYY					
6	MM/DD/YYYY					
		Total (총액) ----▶				

④ Communication Consent

I authorize Christian Mutual Med-Aid to discuss any and all health related information including payments with persons(s) listed below.

Contact Person (1)	Full Name (이름)	Address (주소)	Phone Number (전화번호)	Relationship(관계)
Contact Person (2)	Full Name (이름)	Address (주소)	Phone Number (전화번호)	Relationship(관계)

If the case of multiple member/patient submission, each member/patient must fill up separate forms.

Signature of Patient Individual | Print Name of Patient Individual | Date

Signature of Authorized Representative | Print Name of Authorized Representative | Date

OFFICE USE ONLY

Send To: Christian Mutual Med-Aid | 5235 N. Elston Ave. | Chicago, IL 60630
Attn.: Needs Processing Department | Tel. 773-777-8889(Ext.5003) | Fax 773-777-0004