診　療　申　込　書
REGISTRATION FORM

松田整形外科記念病院

Date : Year　Month　Day　※ Please fill out the columns within the bold lines.

Name （氏名）

（性別）Gender : ☐ （男性）Male ☐ （女性）Female

（国籍）Nationality :

Date of Birth （生年月日）

Year :　Month :　Day :

Age :

Address （住所）

〒 (　　—　　)

Contact Information （連絡先）

Phone number : (　　)

Mobile phone number : (　　—　　—　　)

Workplace :　Phone number : (　　)

Address of workplace :　Occupation :

Name of school :　Grade/Year :

（本日受診される科をお選び下さい。）
Please choose the department in which you hope to see a doctor today.

☐ Orthopaedics　☐ Dentistry

（交通事故によるお怪我ですか？）
Were you injured due to a traffic accident?

☐ Yes → Accident date and time　Year :　Month :　Day :　AM / PM about :

☐ No　Place of accident :

driver's seat ・passenger's seat ・rear seat ・in a taxi ・motorcycle ・bicycle ・walking

（業務中、または通勤途中によるお怪我ですか？）
Did you get injured during work or while commuting to or from work?

☐ Yes → ☐ Working (Industrial accident , Accident in line of public duty)　Person in charge

☐ No　☐ Commuting (Accident while commuting)　(　　)

◆ Our hospital pages patients by their full name to prevent medical error and to ensure safe communication.

◆ Please show your Health insurance card, Public medical expense assistance insurance card etc. to the reception.

◆ If you have a letter (referral documents etc.) and date of your last X-ray or scan (film or CD-ROM) please hand them to someone at the reception.

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