Registration form

No.

Please fill in the thick frames.

①Have you ever been to Aso Iizuka Hospital?	Yes ・ No
②Do you have a referral letter from another hospital?	Yes ・ No
③Do you have an appointment?	Yes ・ No
④Do you have Japanese health insurance?	Yes ・ No

⑤Please place a check mark on the department you would like to visit today.

✔	Department
	Hepatology
	Respiratory Medicine
	Endocrinology, Diabetes and Metabolism Medicine
	Hematology
	General Internal Medicine
	Pediatrics★
	Nephrology and Hypertension
	Surgery
	Obstetics and Gynecology
	Pediatric Surgery★ (Closed Tuesdays and Thursdays)
	Neurosurgery (Closed Mondays and Wednesdays)
	Dentistry and Oral Surgery★
	General Thoracic Surgery
	Plastic and Reconstructive Surgery (Closed Tuesdays and Thursdays)

✔	Department (Appointment(*) or referal letter(Gray colored) needed)
	Gastroenterology
	Radiology★ *
	Psychiatry★ *
	Cardiology
	Orthopedics Surgery
	Urology
	Ophthalmology (Closed Wednesdays)
	Ear, Nose and Throat
	Dermatology
	Cardiovascular surgery★ *
	Physical Medicine and Rehabilitation ★ *
	Neurology★ *
	Psychosomatic Medicine ★ *
	Rheumatology *
	Kampo Medicine★ *
	Palliative Care★ *

⑤Please write your name, address, telephone number and nationality.

Family name	First name	Maiden name	Sex	◎ For any changes, please let us know at the first visit reception.
			M・F	

Birth date	mm/dd/yy	Age	Nationality

Address	〒　　-

Phone number ( )	Cellphone number ( )

For office use only

紹介状	★ 問不要 / CD フィルム 預かる	保険証	患者ID	診察券
有 ・ 無				有 ・ 無

★ 開封確認 紹介状 預かる	新番 / 保・住 / チェックのみ / 連携	備考	担当者	確認者

受付	入力	Wチェック	保険証 問診票渡し			
:	:	:	:	:	:	: