

新竹馬偕紀念醫院初診基本資料單

Hsinchu MacKay Memorial Hospital First Visit Patient Registration

日期(Date)：_____年(Y)_____月(M)_____日(D)

姓名 Date of Birth					First Name /Surname				
出生日期 Date of Birth	_____年(Y)_____月(M)_____日(D)				國籍 Nationality				
身分證號碼 ID No.								性別 Gender	<input type="checkbox"/> 男(M) <input type="checkbox"/> 女(F)
手機 Cell Phone					電話 Telephone	()-			
住址 Address									
電子信箱 E-mail					郵遞區號 Zipcode				
緊急聯絡人 Emergency Contact Person	姓名 Name				電話 Telephone	()-			
					手機 Cell Phone				
	關係 Relationship		地址 Address						
<p>本院及醫療體系(台北、淡水、新竹及台東)於醫療及照護服務之前提下，蒐集、處理及利用本人於體系之病歷記錄資料。 依個人資料保護法第5條至第9條、16條、20條等規定 本人是否同意醫院以信件、e-mail、簡訊、傳真、電話等聯絡方式，通知醫師休診或代診、衛教、健檢、病友會、院訊、門診表、醫療新知、教學活動、關懷及滿意度等相關資訊，如不同意連絡通知，本院將無法通知前述資料。 The Hospital and health care system (Taipei, Tamshui, Hsinchu and Taitung) under the premise of health and care services, collection, processing and use of personal information in the medical record system of records. According to 5-9, 16, 20, etc. of the Personal Data Protection Law, do I agree that the hospital inform about DR. duty off or substitute, medical consultation, patient association, hospital information, outpatient form, medical news, teaching activities, care, satisfaction and other related information by letter, email, fax, message, telephone, etcif you do not agree to contact notice, our hospital will not be able to notify the aforementioned information.</p>									
<input type="checkbox"/> 同意 Agree <input type="checkbox"/> 不同意 Disagree									
立同意書人/法定代理人簽名(Sign)：					關係(Relation)				