Registration Chart

	For Admission Use	▣
Dr.		<u> </u>
Room:	(class)	
Date:		

仁安醫院

Please 1	Use ID Label or I	Block Print				
SURNAME			UNIQUE RECORD NO			
GIVEN NAME			CHINESE NAME			
SEX	AGE	WARD	ATTENDING DATE & TIME			
ATTN.	DOCTOR:					
CONTER	TIT DOCTOR					

Room:(class)		NION HOSPITAL	GIVEN NAME		CHINESE NAME
Date:			SEX AGE	WARD	ATTENDING DATE & TIME
Adm @:	R	egistration Chart	ATTN. DOCTOR: CONSULT. DOCTOR		
I. Personal Information	Your personal	information listed below are nec	- 1		re and treatment
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Medical Record No. URN (Office	cial Use Only)	* Please use English	ı (in BLOCK Letter)	if possible	☐ Tick as appropriate
English Name*	rname)			. N	
Chinasa Nama	*	w	·	iven Name)	
(if available)	Se	x ☐ Male / ☐ Female	Date of Bir	Day	Month Year
Nationality	Identification Document No.		People's Reput of China ID No		
	Document 110.		_ 01 Clima 15 14	<i></i>	
Address* Flat Floor		Block / Name of Building			Name of Estate
Street N	o. & Name	District			Zone
Mailing Address ☐ Same as above ☐	Other				
Telephone (Home)		(Mobile) (HK / Macau / Chi	na / Others)		
				(1	for receiving SMS messages)
E-mail Address		Known Allergy			
Remarks					
II. Next of Kin Information	(Please prov	vide at least one next of kin info	rmation)		
1 Name		Relationship	Remark	s	
Contact No.		Contact No. (HK / Macau /	China / Other Area		
				(1	for receiving SMS messages)
2 Name		Relationship	Remark	s	
Contact No.		Contact No. (HK / Macau /	China / Other Area		for receiving SMS messages)
III A alemanda da amanda af tha Info		Content of Heavital Dule			
III. Acknowledgement of the Info		<u> </u>	<u>s</u>		
✓ I have been provided the information	0	• •			
☑ I acknowledge and understand the co				_	
✓ I understand and agree that, during the and medical information (including a					
for the collective purposes of clinical					
that, as a result, my / my minor's /	•		•		_
doctor(s), other medical and nursing may become involved in clinical ma					
the systems being used in all affiliate					
medical and personal data to the Co	ourt if ordered of	or subpoenaed by the Court, to			
required by law, or to other agencies	for public health	purposes.			
☑ I understand that one of the purpose					
hospital fees, if any, against me, a Hospital's solicitors and/or debt coll					
reserves the right to disclose my pers			are purpose of	10001019	or sustainant nospital foot
☑ I hereby authorize Union Hospital	to obtain my /	my minor's / my ward's med	dical information	n from oth	ner hospital(s) or healthcar
institution(s) for the purpose of factors hospital or healthcare institution.	ilitating continui	ity of patient care, should in a	ny case, either I	or my mi	nor is transferred to anothe
☐ Union Hospital will regularly distrib			_		=
mails, e-mails or electronic messages ☐ I refuse SMS for admission or follow	-	ant to subscribe to this free new	s service, please	tick the bo	Χ.
Preferred communication language	v-up reminders. ☐ Chin	ese			
r referred communication language	□ Ciiin	CSC — EIIgIISII			
Signature of Client / Guardian		Date			