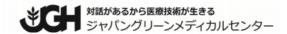
## **JAPAN GREEN MEDICAL CENTRE LTD**



## Registration form for new service users

Full name of patient

City Clinic: 10 Throgmorton Avenue London EC2N 2DL Tel: 020 7330 1750 Fax: 020 7330 1751

Acton Clinic: Unit 7-8 Acton Hill Mews 310-328 Uxbridge Road London W3 9QN Tel: 020 7330 1750

Print name (	)氏名(	)		
<u>Title</u> ( Mrs / Mr / Ms /Miss / Dr / Others ;		)		
Gender (Male / Female / Prefer not to say )				
Date of birth (DD/MM/YYYY;		)		
Home address (		)		
Home/mobile telephone number (Home;	Mobile;	)		
E-mail address (		)		
Other contact details: employer/work/school/insurance purposes): Name;	ance company (if applicable) Address;			
Insurance company (for invoicing or insurance purp Name;	oses): Insurance number;			
Others:				
Emergency contact Name;	Relationship (if needed);			
Address;				
Phone number;				
Name and address of GP (General practitioner of NHS) (if applicable) Name of GP;				
Address of GP;				

以下のうちご希望の連絡方法をお知らせ下さい。当院での医療サービスに必要な場合のみ、ご本人もしくは保護者へご連絡を差し上 げる場合がございます。(複数選択可)

<sup>\*</sup>Please tick the boxes as your contact preferences. We may contact you for our medical services only when needed. (Tick all that apply)

☐ Mobile phone	☐ Text message	☐ E-mail	$\square$ Home telephone	☐ Home address	☐ Company address
$\ \square$ Others ( details;					)

We would be grateful if you could answer the following questions prior to your consultations in order for your doctors to fully understand your medical problems.

ジャパングリーンメディカルセンター (以下、JGMC) をご利用になるにあたり、以下の質問に正確にお答え下さい。1) から3) は、安全かつ適切な医療サービスを提供させて頂くために必要な情報です。□にチェックしてください。「はい」とお答えの場合は詳細をお知らせ下さい。

1)Have you been on a treatment for any medical cor現在治療中の傷病をお持ちですか?	ndition	ns?		
□ Yes はい (Details 詳細;	)	$\square$ No	いいえ	
2) Have you had any operation, in-patient care, long 過去に入院、手術、長期通院治療、薬物による副作用を経験	_		_	
	したこ			
☐ Yes はい (Details; )		⊔ No	いいえ	
3) Have you ever had any allergic reaction before? これまでに何らかのアレルギー反応を経験したことがありま	すか?			
□ Yes はい (Details ;		$\square$ No	いいえ	
Please read the contents listed below and tick the boxe 以下の内容をご確認のうえ、同意なさる場合は、□ にチェ		_		
□ I agree Japan Green Medical Centre(JGMC) keeps at securely according to The General Data Protection Reg 1998 and The Access to Health Records Act 1990.  JGMCが医療サービスのために必要な私の個人情報をThe General Data Protection Reg 1998 Act 1998及びThe Access to Health Records Act 1990に従っ	ulatio eral Dat	n, The Da	on Regulation, The Data Protection	Human Rights Act
□ I give the pre-authorization of blood tests regarding in advance to JGMC when the tests are required urgen 医療従事者の針刺し事故対応を目的として、予め採取された必要となる場合は、これを事前に許諾します。	tly as	a procedu	ure for needle stick injury.	·
☐ I wish JGMC to share my medical record with my N	HS GP	. (Please k	be aware we may write to yo	our GP regarding
your visit if you agree with this.) JGMCが私のNHS GPと私の診療記録を共有することを希望 受診情報を送付する場合がございますことにご留意下さい。 * Further information on how JGMC uses your personal data can be found on the JGMC views your personal data can be considered as a constant of the personal data can be considered as a constant of the personal data can be considered as a constant of the personal data can be considered as a constant of the personal data can be considered as a constant of the personal data can be considered as a constant of the personal data can be considered as a constant of the personal data can be considered as a constant of the personal data can be considered as a constant of the personal data can be conside	します。)	。(この項	頂に同意されている場合は、登	録されているGPへ
Please fill in all blanks below if you confirm the information provided by JGMC.( You can refer to the general guidar 上記内容に相違がないことを確認し、JGMCにおける医療サービス利用に関するご案内はGuide for service user及び	nce fo	r service เ 利用を希望	users.) 望される場合は、以下の必要事	
Name of service user (print name) (				)
Name of Parent or Guardian (for children and young po	erson	under the	e age of 18)	)
Signature of service user (parent or guardian if necessar	ary)			)

Date of signature (DD/MM/YY)
(

)