# REGISTRATION FORM

[診療申込書]

ＮＴＴ Medical Center Tokyo

**Please fill in the blanks.**

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|---|---|---|---|---|---|
| 申込日 | 年 | 月 | 日 | | |
| Ｎａｍｅ | (kana)<br>(English or Your Mother Language)<br>Family Name Given Name | Sex | Male(男性) ・ Female(女性) | | |
| | | Date of Birth | YYYY | MM | DD |
| Address | Residence or Accommodation in Japan 【住所または日本での滞在先】<br>〒 | | | | |
| Telephone | (Mobile) (Home) | | | | |
| Nationality | | Native Language | Other(s) | | |
| Emergency Contact 【緊急連絡先】 | Name Relationship【関係】<br>Address<br>Telephone (Mobile) Telephone (Office) | | | | |
| Passport or Residence Card No. | | | | | |
| Special Requirements for Religious Reasons 【宗教上の理由により特別の配慮が必要な事項】<br>☐Foods ☐Others ( | | | | | |
| Visa Status 【在留資格】 | ☐Resident (w/ card) 在留カード ☐Diplomat/Official Resident 外交・公用 ☐ Stationing U.S. Forces 駐留米軍<br>☐ Temporary-Stay 短期滞在 (☐Tax exemption card 免税カード) ☐ Medical-Stay 医療滞在 | | | | |
| Japanese Health Insurance 【日本の保険】<br>☐National Health Insurance ☐Others ☐Uninsured<br>☐Social Health Insurance (Company Name Company Telephone Number - - ) | | | | | |

Please be advised that Overseas Health Insurances are not acceptable. **【海外の保険使用不可】**

02：Cardiology / 03：Gastroenterology / 04：Neurology / 05：Hypertension & Nephrology / 06：Endocrinology & Metabolism / 07：Hematology
10：General Medicine / 11：Psyhosomatic Medicine / 12：Neuropsychiatry / 14：Respiratory Medicine / 16：Thoracic Surgery / 17：Pediatrics
21：Surgery / 31：Neurosurgery / 32：Stroke Unit / 33：Gamma Knife Center / 34：Cardiovascular Surgery / 37：Orthopedic Surgery / 51：Dermatolog
54：Urology / 57：Gynecology & Obstetrics / 61：Ophthalmology / 64：Otolaryngology / 77：Dentistry & Oral Surgery / 81：Pain Clinic / 92：ER

**USE OF PERSONAL INFORMATION**

NTT Medical Center Tokyo takes all possible measures to ensure that all personal information under the following uses shall be regarded as confidential and available only to the authorized individual(s) or the third party.

Ⅰ INTERNAL USE
1 Medical Services to Patients
2 Health Insurance Claim
3 Ward Management for Hospital Admission and Discharge
4 Billing and Payment
5 Medical Incident Report
6 Medical Services Improvement to Patients
7 Cooperation to Clinical Training
8 Cooperation to Clinical Study for Healthcare Quality Improvement
9 Patient Management and Others

Ⅱ EXTERNAL USE
1 Regional Partnership Together with Health Care Providers (Hospitals, Clinics, Maternity Hospitals, Pharmacies, Home Nursing Stations, or Nursing Care Services), or Other Parties
2 Referral Response to Health Care Providers or Other Parties
3 Request for External Review to Health Care Providers or Other Parties for Patient Care
4 Outsourcing Laboratory Services
5 Informed Consent from Patients' Families
6 Outsourcing Health Insurance Claim Services
7 Health Insurance Claims Provision to Health Insurance Claims Review & Reimbursement Services (HICRRS)
8 Inquiry Response to HICRRS or Insurers
9 Physical Examination Result to Insurers or Other Parties
10 Request for Consultation or Claim to Specialized Organizations or Insurance Companies regarding Medical Professional Liability Insurance or Other Insurances or Other Insurances
11 Application for Registration or Renewal as A Member of Cancer Care District Liaison Hospitals and A Member of Japanese Association of Cancer Registries (JACR)
12 Anonymizing Medical Information Provision to Ministry of Health, Labour and Welfare (MHLW) and Pharmaceuticals and Medical Devices Agency (PMDA) for Medical Safety Measures of Pharmaceuticals and Medical Devices.
13 Anonymizing Medical Incident Information Provision to Consumer Affairs Agency (CAA) and National Consumer Affairs Center of Japan (NCAC) for Patient Protection, Public Hygiene Improvement, and Child Health Development
14 Health Insurance Claim and Others

Ⅲ OTHER USE
1 Study Materials for Maintenance and Improvement of Medical Services and Nursing Care Service
2 Medical Information Provision to External Auditors

I hereby give consent to NTT Medical Center Tokyo to use and disclose my personal information for the purposes as mentioned above.

Date (year/month/day) Signature of Patient