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| 医師名 | | |  | | | | | | | | | | | | | | TEL | | | | | | |  | | | | | | | | | | |
| 医療機関名 | | |  | | | | | | | | | | | | | | FAX | | | | | | |  | | | | | | | | | | |
| フリガナ | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 患者住所 | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| フリガナ | | |  | | | | | | | | | 旧姓 | | | | | 生年月日 | | | | | | | T・S・H・R　　　　年　　　月　　　日 | | | | | | | | | | |
| 患者氏名 | | |  | | | | | | | | |  | | | | | 性別 | | | | | | | □男　　□女　　（　　　歳） | | | | | | | | | | |
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| 当院受診歴 | | | □有　　　　　　　□無 | | | | | | | | | | | | | | 黒部市民病院ID | | | | | | |  | | | | | | | | | | |
| 希望科 | | |  | | | | | | | | | | | 診断 | | | | | |  | | | | | | | | | | | | | | |
| 保険者番号 | | |  |  |  |  |  |  |  |  |  | | | | 枝番 | | | |  | |  | 被保険者名 | | | | | 本人・家族 | | | | | | | |
| 保険証 | 番号 | |  |  |  |  |  |  |  |  |  | |  | |  |  | |  |  | |  | 負担割合 | | | | | 割 | | | | | | | |
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| 資格開始日 | | |  |  |  |  |  |  |  | 終了日 | | | | |  |  | |  |  | |  |  |  | |  |  |  |  |  |  |  |  |  |  |
| 老人及び公費 | 公費負担者番号 | | | | | | | | 受診番号 | | | | | | | | | | 資格開始日 | | | | | | | | | 資格終了日 | | | | | | |
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* 太枠内の保険情報の記入をお願いします。
* 受診当日の受付手続きを速やかに行うため、紹介状（診療情報提供書）と一緒に事前に患者さんの情報確認のFAXをお願いします。
* 指定された医師が不在の場合、他の専門医が診察されて頂く場合がありますので、ご了承ください。

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| 診察予約申込書  黒部市民病院　地域医療連携室　フレンディー  TEL 0765-56-7230（直通）  FAX 0765-54-2981 |