

# Taichung Veterans General Hospital Registration Form (First-time Visitor)

Index No. ( staff only )

Name:	Date of birth:	Place of birth:
ID number:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single
Permanent address:		
Correspondence address:		
Email:	Covered by other insurances: <input type="checkbox"/> Yes _____ <input type="checkbox"/> No	
Home/Office phone:	Cell phone:	
Hospitals previously visited for this illness:		
Date of first visit:	Dept. visited:	Blood type: _____
Occupation:	National Health Insurance: <input type="checkbox"/> Covered <input type="checkbox"/> Not covered	
Contact person in emergency:	Relationship to the patient:	Phone (H): Cell phone: <b>required</b>
ID (original copy with photo): <input type="checkbox"/> ID card <input type="checkbox"/> NHI card <input type="checkbox"/> Driver's license <input type="checkbox"/> Alien Resident Certificate <input type="checkbox"/> Passport	Allergies to medicine: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> Quitted <input type="checkbox"/> No (If No, Skip the following) <input type="checkbox"/> Cigarettes <input type="checkbox"/> Electronic cigarettes/VAPE <input type="checkbox"/> Tobacco <input type="checkbox"/> Less than 10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> Over 31 No./per day for <input type="checkbox"/> Less than 10 <input type="checkbox"/> 11-20 <input type="checkbox"/> Over 21 years Do you want to quit smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Exercise in the past 2 weeks: <input type="checkbox"/> Yes <150mins <input type="checkbox"/> Yes >150mins <input type="checkbox"/> No	
	Betel nuts chewing: <input type="checkbox"/> Yes _____ nuts /day for _____ years <input type="checkbox"/> Quitted <input type="checkbox"/> No	
	Drinking in the past half year: <input type="checkbox"/> Occasionally for _____ years <input type="checkbox"/> Frequently for _____ years <input type="checkbox"/> Quitted <input type="checkbox"/> No	
	Note: 1. Our hospital offers an app for accessing medical information. Please provide your most up-to-date personal information, with your mobile phone number. 2. After completing the form, please submit it along with your identification documents, health insurance card (if any) to the counter staff for processing.	

Staff: staff only

**P.S. If you are a foreigner without National Health Insurance coverage, fees will be assessed with an international medical surcharge. For detailed pricing information, please refer to our International Medical Service Center website or scan the QR code.**

