|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名  (Name) |  | | | | | | | | | |
| 身份證字號  (ID/Passport No.) |  |  |  |  |  |  |  |  |  |  |
| 出生日期  (Birth of date) | 年(Y) 月(M) 日(D) | | | | | | | | | |
| 看診科別  (Dep.) |  | | | | | | | | | |
| 看診日期  (Date) |  | | | | | | | | | |
| 看診時段  (Period) | □上午 □下午 □夜診 □不指定 | | | | | | | | | |
| 看診醫師  (Doctor) | 醫師 □不指定 | | | | | | | | | |
| 掛號回傳電話  (Fax.) |  | | | | | | | | | |

馬偕紀念醫院 聽障傳真預約掛號