SANDY CREST MEDICAL CENTRE REGISTRATION FORM

Patient Information:

Mr. ❐/Mrs. ❐/Miss❐/ Dr❐ Last Name: ___________________M/I: _______First Name: _______________

Date of Birth: Mnth: ______ Day:_______ Year:________ Age:_______ Nationality:_________________

Postal Add:____

Home Tel. No:_______________ Cell:_____________ Work Number:_________________ Ext:________

Email Add____________________________________ Referred By:_______________________________

Occupation:__________________________________

Local Address (if visiting):____ Tel No:_________

Preferred Method of contact: Home❐/ Cell❐/ Work❐/ Email❐/Other:________________________

Next Of Kin: Contact No:

Business/Insurance Information:

Insurance Carrier: Sagicor❐; ICB❐; CLICO❐; BA❐; GG❐; Tatil❐; ALICO ❐;

Other:____

Employer:_____________________________________ Business Address: ______________________

Plan:____ Business Telephone:_____________________

Group #:_____________________________________ Insured:________________________________

Relation:____________________________________

Health Information:

Height:___________ cm/ft Weight:__________ kg/ lbs Disabilities:_______________________

Allergies:____

Have you ever suffered/ are suffering from any of the following? Please tick the appropriate box(es).

High Blood Pressure❐ Diabetes❐ Heart problems❐ Stroke ❐ Asthma/ Bronchitis❐

Seizures/ Fits ❐ Hay Fever❐ Pneumonia ❐ Jaundice❐ Kidney Disease ❐

Sickle Cell Disease ❐ Cancer❐ Tuberculosis ❐ Arthritis❐ Acid (Stomach) ❐

Other____

Do You Use: Cigarettes? Alcohol? Other? ____

Medications presently taking: a)______________________________ b)__________________________

c)_________________________ d)______________________________e)__________________________

Comments:____

Identification:

Ancillary Information:

Eye Doctor:

Name: _____________

Last Consult:________

Dentist:

Name:_____________

Last Consult:_______

Last ECG:__________

Last Blood Sugar:____

Last Full Medical:___

Last Cholesterol:____

Last PSA/ PAP:_____

Method of Payment:

Cash: ❐

Cheque: ❐

Debit Card: ❐

Credit Card: ❐

Other: ❐