APOLLO MEDICAL CENTRE

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Patient Registration Form

Patient Name: _____ _____
Last *First*

Date of Birth: _____ Age: _____ Sex: Male/ Female/ Other

Health Card No: _____ Version Code: _____ Exp. Date: _____
Please write UCI / UHIP number if applicable

Address: _____

Contact No: _____ _____ _____
Cell phone *Home* *Work*

E-Mail Adress: _____
Please note that clinic would be contacting you via email for medical comunication

Emergency Contact Information

Name: _____ Contact No: _____

Relationship: _____

Reason for Today's Visit : _____

Medical History

Allergies: _____

Current Medical Illness: _____

Past Medical Illness: _____

List of Current Medication : _____

Do you have a Family doctor: ☐ Yes ☐ No Are you looking for Family doctor: ☐ Yes ☐ No

Are you up-to-date on your immunization: ☐ Yes ☐ No

Date of your last complete physical examination : _____

I hereby agree the above past & current medical information is true and accurate to the best of my knowledge

_____ _____
Patients Signature Date of Registration