ARMADA MEDICAL CENTRE

CURING THROUGH CARE

WELCOME

Thank You for selecting our healthcare team, we will strive to provide you the best possible health care. To help us meet all your needs, please fill out this form completely. If you need assistance, Please ask us – we will be happy to help you.

1. Personal Information

Patient's name:	Phone number:
Postal Address:	Work Phone:
City:	E-mail address:
Nationality:	☐ Resident ☐ Visit Visa
Sex:	Date of birth:
Occupation	Marital Status
Company name	

2. Insurance Information

(To be filled by clinic staff)

Name of Insured:	
Insurance Company:	Validity:
Policy Number:	
Deductible:	

3. Patients Medical History

☐ Asthma	☐ Diabetes	☐ Previous Surgeries
☐ Heart Disease	☐ Kidney Disease	
☐ Malignancy Disease	☐ Smoking	
☐ Thyroid Disease	☐ Alcohol	
☐ Hypertension	☐ Allergy	

4. Family History

	Age	Diseases
Father		
Mother		
Sibling		
Grandfather		
Grandmother		
Other Family members		

5. Please list down any medications you are currently taking:

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6. How did you hear about Armada Medical Centre? ____________________

Patients Signature: ____________________ Date: ____________

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