THE CENTRE FOR DIGESTIVE HEALTH

PATIENT REGISTRATION

P.O. Box SS-6587
Nassau, Bahamas

PATIENT INFORMATION:

NAME ______________________________

SEX ______________________________

STREET ADDRESS ______________________________

P.O. BOX ______________________________

ISLAND/COUNTRY ______________________________

BIRTHDATE ______________Age______________

PHONE#(S) home ______________________________

cell ______________________________

fax ______________________________

PLACE OF EMPLOYMENT

Name ______________________________

Address ______________________________

Phone no. ______________________________

NATIONAL INSURANCE NO. ______________________________

REFERRED BY: ______________________________

NEXT OF KIN Name ______________________________

Phone# ______________________________

Address ______________________________

BILLING INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT:

Name ______________________

Address ______________________

P.O. Box ______________________

Phone #(s) ______________________

Place of Employment______________

Signature ______________________

Insurance Name______________________

Policy Holder______________________

Certificate # ______________________

Policy #______________________

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Dr. Harold A. Munnings.
I understand that I am financially responsible for any balance not covered by my insurance.

Signature ______________________________ **Date** ______________

The Centre for Digestive Health

Name ______________________ ☐ New ☐ Consult

1. Reason for your visit ______________________

2.Indicate if you are having any current problems, signs or symptoms in any of the following areas:

√	√
☐ General Wellness	☐ Neurological
☐ Eyes	☐ Allergies
☐ Skin	☐ Reproductive/Urinary
☐ Ears, Nose, Throat	☐ Thyroid/Endocrine
☐ Stomach/Digestion	☐ Psychiatric
☐ Lungs/Breathing	☐ Blood/Lymph
☐ Heart Circulation	☐ Other
☐ Muscles/Joints/Bones	☐ Other

Physician Comments - Review of Systems

☐ All others systems negative

3. Medication(s) (drugs, pills)

4. Previous Surgeries/Dates

5. Allergies

6. Social History Marital Status: Single ☐ Divorced ☐ Married ☐ Widow/Widower ☐

Who lives with You? ______________________

Current Occupation/Employer ______________ What kind Work? ______________

Do you smoke? ________ How many packs a day? _____ For how many years? ______________

Do you drink alcohol? ________ How many drinks per day? _____ per week? _____ per month? ________

Are you sexually active? ________ Do you use illicit drugs? _______ If yes what kind? ______________

7. What is the Health Status of Your Family?

Mother: ______________________

Father: ______________________

Brothers/Sisters: ______________________

7. Family Illnessess

History of Heart Disease (heart attack, heart failure) ☐ Yes ☐ No History of Strokes? ☐ Yes ☐ No

History of High blood pressure? ☐ Yes ☐ No History of diabetes? ☐ Yes ☐ No

History of cancer? ☐ yes, site ______________________ No

HISTORY - Reviewed by Doctor