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. _____

EMAIL _____

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