

# WELCOME TO SANDY CREST MEDICAL CENTRE

Patient Information: DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

Mr. /Mrs. /Miss/ Dr Last Name: \_\_\_\_\_ M/I: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: Mnth: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Age: \_\_\_\_\_ Nationality: \_\_\_\_\_

Address: \_\_\_\_\_

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; BRYDENS; 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 Number:

Ancillary Information:

**Eye Doctor:** Name: \_\_\_\_\_ Last Consult: \_\_\_\_\_

**Dentist:**

Name: \_\_\_\_\_ Last Consult: \_\_\_\_\_

Last ECG \_\_\_\_\_ Last Blood Sugar \_\_\_\_\_ Last Full Medical \_\_\_\_\_

Last Cholesterol: \_\_\_\_\_ Last PSA \_\_\_\_\_ Last PAP \_\_\_\_\_

## Method of Payment:

Cash:  Cheque:  Debit Card:  Credit Card:

Other: