222B

New Patient Pre-Registration Form

Patient N°
(For clinic use only)

PHYSICAL HEALTH & HEALING CENTER

Personal Information

First Name: ..... Last Name: .....

Date of Birth: ..... Gender: Male ☐ Female ☐

EID/Passport N°: ..... Occupation: .....

Nationality: ..... City of Residence: .....

Mobile N° ..... E-Mail: .....

Emergency Contact Person

Full Name: ..... Relation: .....

Phone N°: .....

How did you hear about us?

Practitioner Referral ☐ Referrer's Name: .....

Social Media ☐ Which one? : .....

Our Website ☐

Someone *(Please specify)* ☐ .....

Do you have an insurance? ☐ Yes ☐ No

If yes, please specify your insurance company name & Insurance N°: .....

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Chief Complain

.....

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How long have you been experiencing this pain / symptom / disorder?

How would you rate your pain level on a scale of 10? ☐☐☐☐☐☐☐☐☐☐

Do you have any known Allergies? *(if yes, please specify)* ☐ Yes ☐ No

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Are you taking any medication at the moment? ☐ Yes ☐ No

Are you actually following an external treatment? ☐ Yes ☐ No

Date: / /

Signature: