SP HEALTH CLINIC

Patient Registration Form

Please print clearly and legibly. Any errors made on this form may result in errors on your medical record.

PERSONAL INFORMATION

First Name:_____ Last Name:_____

Middle Initial:_____ Date of Birth:_____ Gender: ____M ____F ____Nonbinary

Residing Address:_____

Street Address

City:_____ State: _____ Zip Code:_____

Phone Number:_____

(If you do not have a US phone number, you may leave this section blank)

Email Address:_____

Do you have U.S. Health Insurance? *If yes, please complete section below.*

Insurance Name:_____ Member#:_____

(ex. HMSA, Anthem, Cigna, BlueCross BlueShield)

MEDICAL HISTORY

Do you have any medical conditions?	Surgeries? Please include date(s)
Medications you're currently taking:	Allergies to any medication? Latex? Iodine? Other?
Do you drink alcohol? If yes, how many drinks per day? How many days per week?	Do you smoke tobacco products? If yes, what type? How many per day?
FOR FEMALES, PLEASE COMPLETE SECTION BELOW	
When was your last menstrual cycle?_____	Are you currently pregnant?_____

IN CASE OF AN EMERGENCY	
Name of Local Friend/Relative (Not living at the same address)	Mobile Number:_____ Work Number:_____

Patient/Guardian Signature:_____ **Date:**_____

If you are under the age of 18 years old, please prepare to have your legal guardian speak to or submit a letter to the clinic stating that you are able to receive care from SP Health Clinic. By signing, you agree that the above information is accurate. I understand that I am financially responsible for any balance that may occur during my visit. I also authorize HPU SP Health Clinic or the insurance company to release any information required to process my claims.