CLB 3 Health – New Patient Information

Name: _____ Date: _____

Task: *Fill in a new patient form with your information*

NEW PATIENT HEALTH FORM

Personal Information:

Title: Mr. ____ Mrs. ____ Ms. ____ Dr. ____

_____ _____ _____

First Name Middle Initial Last Name

_____ _____

Date of Birth: MM/DD/YY Preferred Language

_____ _____ _____

Address City Postal Code

_____ _____

Telephone Number Email Address

Emergency Contact Information:

_____ _____ _____

Name *Phone Number* *Relationship*

Do you have medical insurance? Yes ____ No ____

Health Information:

Do you smoke? Yes ____ No ____

Do you drink alcohol? Yes ____ No ____

Do you have any allergies? Yes ____ No ____ If yes, what are they?

_____

Do you take medication? Yes ____ No ____ If yes, please list below:

_____

At the moment, do you have any symptoms? Yes ____ No ____

If yes, what are they? Please list:

_____

How long have you felt these symptoms?

_____

Patient's Signature:

_____