# 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 the 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 THE 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:_____<br>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.