Staff Use Only:

PID: _____ Date: DD / MM / YYYY

Patient Appointment Time: _____ AM | PM

Patient Arrival Time: _____ AM | PM

New Patient Registration

Section 1: Patient Information

Need Help with Forms? □ Yes □ No

Name: *(Last)*_____ *(First)* _____ *(Other)* _____

Date of Birth: DD / MM / YYYY | Place of Birth: *(City, Country)* _____

Gender: □ Male □ Female □ Other | Contact Number: _____ Alternate Contact Number: _____

Address: _____

Email: _____ | Subscribe to Jahmale Newsletter? □ Yes □ No

Blood Group *(If known)*: _____ Sickle Cell Status *(If known)*: _____

Primary Care Physician *(If applicable)*: *(Name)* _____ *(Phone)* _____

Emergency Contact: *(Name)* _____ *(Phone)* _____ *(Relationship)* _____

Section 2: Payment Information

□ Patient/Self *(Proceed to Section 3)* □ Individual other than Patient *(Proceed to Section 3)* □ Insurance *(Proceed to Section 2.1)*

Section 2.1: Insurance Guarantor

□ Private □ Group □ Group Beneficiary

Insurance Company: _____ | Insurer ID No.: _____

Employer *(Required for Group or Group Beneficiary)*: _____

Section 3: Signatory

Signature of Patient *(if over 18 years old)*: _____ Date: _____

In cases where the Patient is a minor (under the age of 18) or required assistance in completing this form, the person who completed this form must fill in their information below.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

Staff Use Only: **Inputted By:** _____

Guarantor Notes:

Payee: Name: _____ *Confirmation*: □ Yes □ No

For: □ Clinical & Diagnostic Services □ Diagnostic Services □ Date Specified: DD / MM / YYYY

Other Comments: _____

_____

_____