

222C

## New Patient Pre-Registration Form

Patient N°

(For clinic use only)

PHYSICAL HEALTH  
& HEALING CENTER

## Personal Information

First Name: .....

Date of Birth: .....

EID/Passport N°: .....

Nationality: .....

Mobile N°: .....

Last Name: .....

Gender: Male ☐ Female ☐

Occupation: .....

City of Residence: .....

E-Mail: .....

## Emergency Contact Person

Full Name: .....

Phone N°: .....

Relation: .....

## How did you hear about us?

Practitioner Referral ☐

Social Media ☐

Our Website ☐

Someone (Please specify) ☐

Referrer's Name: .....

Which one? : .....

Do you have an insurance? ☐ Yes ☐ No

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

.....

## Chief Complain

.....

.....

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

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

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have any known Allergies? (if yes, please specify)

☐ Yes ☐ No

Are you taking any medication at the moment?

☐ Yes ☐ No

Are you actually following an external treatment?

☐ Yes ☐ No

Date: / /

Time:

Signature:

YOU  
Are the  
Best Reference