Cayman Clinic
Your Friendly Medical Centre

CONFIDENTIAL PATIENT INFORMATION

Dr. Virginia Hobday & Associates

PO Box 11786, Grand Cayman, KY1-1009
Cayman Islands

Telephone: (345) 949-7400 Fax: (345) 949-9045

PATIENT REGISTRATION FORM

CHART# _____

TODAY'S DATE _____
DD / MM / YY

Last Name: _____

First Name: _____

Preferred Name: _____

Date of Birth: _____
Day Month Year

Gender: M / F

Home Phone #: _____

Cell #: _____

Work #: _____

Email: _____

Address: _____

_____

P.O. Box: _____ KY1- _____

Occupation: _____

Employer: _____

Employer phone#: _____

Emergency Contact:

Name: _____

Telephone #: _____

Relationship: _____

INSURANCE INFORMATION - PRIMARY INSURANCE INFO

Insurance Company _____

Group # _____ Policy/ID# _____ Plan Name: _____

Company Name *(Under which policy is registered)*: _____

I, the undersigned certify that I (or my dependant) have insurance coverage with:

_____

And assign directly to Cayman Clinic Ltd. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

Signed: _____ Date: _____

Signed by parent or guardian if patient is a minor: _____

*** PLEASE CONTINUE OVER LEAF

All Current Medications (including supplements):

Medication Allergies:

Current Medical Conditions:

Past Medical Conditions / Surgical Procedures:

Other Doctors / Specialists you have consulted & why?

Smoker: Yes / No Alcohol: Yes / No, how often per week? _____

Last Wellness Check:

Date: _____ Where: _____

Height: _____ Weight: _____

How did you hear about us? _____

WOMEN'S HEALTH

Pregnancies (Date / Year) _____

1st day of Last Menstruation: _____ Family Planning (Birth Control): _____

Cervical Smear / Pap Smear (Date & Result): _____

Mammogram (Date & Result): _____