

## Patient Registration Form

*(All information will be kept strictly confidential)*

### Personal Information

Full name:	
Date of Birth (DD/MM/YYYY):	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Nationality:	
Address:	
Phone (Home):	
Phone (Mobile):	
Email:	

### Emergency Contact

Name:	
Relationship:	
Phone:	

### Insurance Information

Insurance Provider	
Policy Number:	
Employer (if applicable)	

**Family Physician (if different from this clinic)**

Name:	
Contact Number:	

**Medical History**

Do you have, or have you ever had, any of the following? (Please tick)  Diabetes

- Hypertension (High Blood Pressure)
- Heart Disease
- Stroke
- Asthma
- Epilepsy
- Cancer
- Kidney Disease
- Thyroid Disorder
- Mental Health Condition
- Other: \_\_\_\_\_

**Family History**

Do you have a family history of any of the following? (Please tick)

- Diabetes
- Hypertension (High Blood Pressure)
- Heart Disease
- Stroke
- Bleeding Problems
- Cancer
- Mental Health Condition
- Other: \_\_\_\_\_

**Current Medications:**

\_\_\_\_\_

**Allergies (drug, food, or other):**

\_\_\_\_\_

**Past Surgeries or Hospitalizations:**

\_\_\_\_\_

**Lifestyle**

- Do you smoke?  Yes  No
- Do you consume alcohol?  Yes  No
- Do you exercise regularly?  Yes  No

# Patient Consent Form

I, the undersigned, hereby consent to the following:

1. I consent to medical consultation, examination, investigations, and treatment as deemed necessary by the medical professionals at Oasis Medical Group (Cayman) Ltd.
2. I consent to the use and storage of my medical records by the clinic in accordance with local laws and professional standards. I understand that my medical information will be kept strictly confidential and will not be disclosed without my written consent, except where required by law or necessary for my treatment.
3. I consent to the release of relevant medical information to my insurance provider (if applicable) for the purposes of processing claims.
4. I understand that I have the right to withdraw my consent at any time by providing written notice to the clinic.

By signing below, I acknowledge that I have read, understood, and agree to the above.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Patient (print): \_\_\_\_\_

If patient is a minor:

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Parent/Guardian (print): \_\_\_\_\_