

## Patient Registration Form

Please fill out to the best of your ability. Information is for medical use only and will be kept strictly confidential

Last Name:		Sex:		<input type="checkbox"/> Female		<input type="checkbox"/> Male	
First, Middle Names:		Date of Birth:	Year	Month	Day		
Address:		Emergency contact:					
		Name:					
		Phone:					
Phone:	Relationship:						
E-mail:	Referred by:						
Guardian(if patient is a minor):					Relationship:		
Will you be using Japanese National Health Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO							
WHAT IS THE REASON FOR YOUR VISIT TODAY?							
CURRENT MEDICATIONS:				CURRENT / PAST HEALTH PROBLEMS:			
				For women: <input type="checkbox"/> Currently pregnant or possibly pregnant			
HABITS:				ALLERGIES:			
Tobacco:	_____ packs/day for _____ years						
Alcohol:	_____ drinks/ozs/mls per day						
Is there anything else we should know to better care for you?							

For staff use only:

BP	/	P	RR	T	PAIN	/10
Comments:						2009-09-29