Registration and Medical Information

Personal Information:

Name: _____ Date of Birth: ____/_____/_19____
Last First Middle

Address: Street:_____City: _____ State: _____

ZIP/Postal Code: _____Home Phone: ( ) _____ Work Phone: ( ) _____

Cell ( ) _____E-mail Address:_____ Gender: ____M ____ F

Passport Number: _____ Passport Expiration Date:_____

Employment and Insurance Information:

Employer: _____ Occupation: _____

Physicians List Certifications/Medical Specialty_____

_____

Employer Address:_____Phone: ( ) _____

Medical Insurance Carrier: _____Phone Number: ( ) _____

Insurance Carrier Address:_____

Name of Policy Holder:_____Member/Policy Number: _____

Primary Care Physician:_____ Phone: ( )_____

Emergency Contact Information:

Name: _____ Relationship to you: _____

Phone Number: ( ) _____ Cell: ( ) _____

Alternate: Name: _____ Phone Number: ( ) _____

Medical History

LIST KNOWN ALLERGIES: (MEDICINES, ETC.)

LIST SIGNIFICANT MEDICAL PROBLEMS

MEDICATIONS TAKEN REGULARLY

DRUG	DOSE	FREQUENCY

PRIMARY PHYSICIAN NAME	SPECIALTY	PHONE NO. (WORK)

ADDRESS CITY STATE ZIP CODE

PLEASE ENCLOSE THE FOLLOWING:

- ❑ A notarized copy of your curriculum vitae (*c.v.*)(MEDICAL PROFESSIONALS ONLY if not already on file)
- ❑ A notarized copy of your board certification or hospital privileges and diploma
- ❑ A photo copy of your passport showing your picture and passport number
- ❑ A notarized copy of your current professional license (RN, MD,DO, DDS etc.)

Upon completion of this form please scan and email to:
ssnyder@hopeclinicinternational.org or mail to:

Hope Clinic International
PO Box 90573
Ypsilanti, MI 48198

_____
SIGNATURE DATE