Patient ID_____

PRIMARY CARE TOKYO

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:		Your current gender identidy:	☐Female ☐Male ☐Other ☐Transgender FTM ☐Transgender MTF		
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? ☐ YES ☐ NO					
WHAT IS THE REASON FOR YOUR VISIT TODAY?					

CURRENT MEDICATIONS:	CURRENT / PAST HEALTH PROBLEMS:
	For women: ☐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:				2016-10-30