HEALTHCARE PROFESSIONALS LTD.
RC: 1602663
HMO | Air Ambulance | Hypaberic Medicine

INDIVIDUAL/FAMILY REGISTRATION FORM

Photograph

Staff ID No._____

General Information

Patient HCP HMO NO.		Reg Date:				Home Tel.	
Name: *(surname first, in capital letter)*						Office Tel.	
Company Name & Address:							
Home Address:							
State:		Fax:			Email:		

Personal Information

Date of Birth:				Nationality:			State of **O**rigin:				
Marital Status:		Sex:	M		**F**		Blood Group:		Genotype:		

Next of Kin

Name: *(Surname first, in capital letter)*						Tel:	
Address:						Tel:	
M		F		Town/City:		Email:	

Spouse	Child 1	Child 2	Child 3	Child 4
Name	Name	Name	Name	Name
Date of BIrth	**Date of BIrth**	**Date of BIrth**	**Date of BIrth**	**Date of BIrth**
Sex	**Sex**	**Sex**	**Sex**	**Sex**
Blood Group	**Blood Group**	**Blood Group**	**Blood Group**	**Blood Group**
Genotype	**Genotype**	**Genotype**	**Genotype**	**Genotype**

Primary care provider chosen and code	
Alternate primary care provider and code	

***[please note that this column is for families that live in different states in Nigeria, e.g principal in Lagos and dependents in Kano*]**

Medical History

Have you ever experienced any of the following:	YES	NO
1. Are you currently on any medication?	0	0
2. If yes, what's the name of the drug(s)?		
3. Have you ever been hospitalized?	0	0
4. If yes, what was the cause(s)?		
5. Have you ever been hospitalized more than once?	0	0
6. If yes, how many times?		
7. Are you allergic to any medication, food or anything else?	0	0
8. Are you pregnant?	0	0
9. If yes, what's the expected date of delivery?		

[please note that all important information must be disclosed, if in doubt, please give details]

Declarations for Members

Please read carefully:

1. I declare that any false statement in the above questionnaire or the non-disclosure of any material fact will render the membership null and void
2. I understand that my membership will be accepted on payment of the subscription fee
3. I hereby give my permission for HCP HMO to have access to any of my medical records,
4. I agree to be bound by the exclusions and definitions found in the member's handbook.

Signature of Applicant…….. Date ……..

If the applicant is under 18years of age, this declaration form must be signed by their parents or legal guardian……..

(For Official Use Only)

Group Number:		Plan:	
HCP-HMONumber:		Service Plan Type:	
Account Number:		Payment Mode:	