

# Patient Medical Record Form Sample: New Patient Registration

## Personal Information

Full Name

Date of Birth

Gender

Select

Address

Phone Number

Email Address

## Emergency Contact

Name

Relationship

Phone Number

## Insurance Information

Insurance Provider

Policy Number

Group Number

## Medical History

Primary Care Physician

**Current Medications (please list all)**

**Allergies**

**Past or Current Medical Conditions**

**Previous Surgeries / Hospitalizations**

**Family Medical History**

List any significant family medical history (e.g., diabetes, cancer, heart disease)

**Lifestyle Information**

**Smoking Status**

**Alcohol Use**

**Exercise Frequency**

**Additional Information**

**Other Information or Concerns**

Submit

**Note:** This form is a sample template for collecting new patients' medical information, ensuring accurate data entry and improved healthcare provider communication.