PATIENT REGISTRATION FORM (UHCP-101)

Today's Date ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Patient's NIC Number ☐☐☐☐☐☐

Patient's Name:

*First ____ Middle ____

*Last ____ Maiden ____

Patient's Personal Information:

*Date of Birth ☐☐ Day ☐☐ Month ☐☐☐☐ Year

*Gender ____ *Marital Status ____

*Birth Place ____ *Residency ____ *Nationality ____

*Religion ____ *Ethnicity ____ Insurance ____

*Occupation: ____ *Employer: ____ Schooling Level: ____

Patient's Contact Information:

*Primary Phone: ____ Mobile: ____ Work Phone: ____ Ext. ____

*Street Address ____ (ex. Carnation Street)

*Community ____ (ex. Black Bay)

*District ____ (ex. Vieux Fort)

*Country ____

Mailing Address / P.O. Box ____

Email ____

Patient's Schooling Information:

*Currently Attending School? Yes/No Name of School: ____ Grade: ____

Next of KIN Information:

NIC Number ____ Relation to Patient ____

First Name ____

Last Name ____

Primary Phone: ____ Mobile: ____ Work Phone: ____ Ext. ____

Street Address ____ (ex. Carnation Street)

Community ____ (ex. Black Bay)

District ____ (ex. Vieux Fort)

Country ____

Mailing Address / P.O. Box ____

Email ____

If this registration information was entered by you on behalf of a Patient, please print:

Your Name ____

Relation to Patient ____

I hereby certify that this information is correct to the best of my knowledge: ____ (signature)

For more information on how to complete this form please call the UHC main office at 452-6756 or fax us at 453-7668 or email us at contact@stluciauhc.org. You may also find downloadable copies of UHC forms and other useful instructions on our website - http://stluciauhc.org. Once completed, this form may be returned to the UHC office main office, or to any public health facility. The contents of this form and any personally identifiable information submitted will be treated with strict confidentiality while in possession of UHC. Presenting false or intentionally misleading registration information is prohibited by law.

*required information, to ensure services provided meet the highest standards

Universal Health Care – A State of Good Health

For Administrative Use:

UHC Eligible: yes ☐ no ☐ Registration Date ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Patient Number: ____ Docket/File Number: ____

Primary Facility: ____ Primary Doctor: ____

Processing Facility: ____ Signature: ____