# BE WELL MEDICAL CENTER

*MEMBER'S REGISTRATION FORM*

The questions marked with (required) have to be answered to file for registration. Please fill in the other information as far as possible/relevant. If you prefer, you can print the form and bring it with you or complete the form during the intake consultation.

First name: _____ Middle name: _____

Family name: _____

Your E-mail: _____

Date of Birth: _____ Female ☐ Male ☐

Height: _____ Weight(kg): _____ Blood Group: _____

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other ☐

Family composition (Thailand) (husband/wife/partner/children):

_____

_____

Nationality: _____ Passport No: _____ Expiry date: _____

Address (Thailand): _____

_____

_____

Telephone: _____

Are you permanently residing in the Hua Hin area: Yes ☐ No ☐

If no, please describe how many months you stay here and which periods:

_____

## Contact person in case of emergency:

Name: _____

Relationship to you: _____

Emergency contact phone number: _____

Emergency contact E-mail: _____

## Mailings and reminders

Members will receive regular updates concerning medical information and developments at our center. Reminders for check-ups, vaccinations etc. will also be sent via email. I consent to being contacted by Be Well MC for above purposes. Yes ☐ No ☐

## Medical history

### Current general health status

Please list any ongoing illness that you have:

_____

Please list any medicines that you take (and doses):

_____

Are you currently, or were you recently, under review by a medical specialist? Please list the illness and name of the hospital/specialist.

_____

If applicable & possible, please bring copies of medical files to the intake consultation.

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## Medical History

Please list any previous significant medical events (diseases, accidents, hospitalization) and indicate if they are still giving you problems.

_____

_____

_____

_____

## Allergies

Do you have any allergies? E.g. food, medicines, insect bites, etc. Yes ☐ No ☐

If yes, please specify: _____

## Vaccinations

If you have a vaccination record book/card please bring it with you to the consultation, or list your vaccines and the dates received (eg Rabies, Tetanus, Hepatitis A/B, Shingles/Zoster, Pneumonia, TB):

_____

## Family history

Is there a history of any serious illness or disease in your close family (e.g. diabetes, asthma, heart disease, cancer): Yes ☐ No ☐

If yes, please specify: _____

## Recent Medical Tests

Have you undergone any tests (e.g. blood, ECG, scans, or other) in the last six months? Yes ☐ No ☐

If yes, please bring the test results to the intake consultation.

**Insurance data**

Do you have medical health insurance? Yes ☐ No ☐

Please provide the name of your insurance company and the type of policy:

_____

While we will keep your personal and medical data strictly confidential, by signing this application form you give us permission to share your information with other medical professionals, medical centers and hospitals if and when we regard this relevant for your treatment.

I affirm that I have answered all the above questions to the best of my knowledge and that the above information is a complete and accurate record of my current health condition including all known medical conditions and other information that may be relevant to my undertaking of the treatments and services provided by the Be Well Medical Center

_____

Name

_____

Signature

_____

Date

*n.b. under Thai law, for children under 20 years of age this form needs to be (co) signed by a legal parent*