INTERNATIONAL MEDICAL GROUP

30 PASADORA PLACE, SMITH ROAD, GEORGE TOWN, GRAND CAYMAN
P.O. BOX 30073, SMB, KY1-1201
PHONE: (345) 945-2881 FAX: (345) 949-4341
EMAIL: INFO@INTMEDICALGROUP.COM

FULL NAME: _____ **GENDER: MALE/FEMALE**

DATE OF BIRTH: _____
Day Month Year

POSTAL ADDRESS: _____ **CODE:**_____

PHONE: _____
MOBILE WORK HOME

EMAIL ADDRESS: _____

EMERGENCY CONTACT _____**PHONE:**_____

RELATIONSHIP: _____**MOBILE NUMBER:**_____

EMPLOYER NAME:_____

MEDICAL INSURANCE:_____**POLICY #**_____

I understand that I am financially responsible for the payment of all services rendered at the time of service.

In the event that the amount due is not timely paid, I understand a monthly service fee of 10% will be charged on any overdue balance and after 60 days, the account will be handed over for collection.

SIGNATURE: _____ **DATE:** _____

(Patient or Parent/Guardian)

Please circle the appropriate response. Where you have answered "YES" to any question, please elaborate.

1. **Do you have any known allergies to foods, medications or other?** **YES NO**
   _____
2. **Are you currently taking any medications or supplements?** **YES NO**
   _____
3. **Is there any personal or family history of diabetes or hypertension?** **YES NO**
   _____
4. **Do you suffer from any chronic medical conditions?** **YES NO**
   _____
5. **Have you ever been treated for Heart Trouble, Ashtma, Epilepsy, Kidney or Liver disease, or a bleeding disorder?** **YES NO**
   _____
6. **Please list any serious operations undergone in the past 5 years.**
   _____