Beacon Ear Nose Throat & Snoring Centre(Co Reg No. 53227367B) Managed by Beacon Medical Pte Ltd

Name(as in NRIC/Passport):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please underline Surname/Family Name*

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: M / F Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nationality:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NRIC/Passport No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address(Home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address(Office):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel(HP)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel(Home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next-of-kin/Accompanying Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Please indicate name and relationship*)

Have any of your family members/relatives consulted at this clinic? Yes / No

If yes, please state relationship and name:

Medical History

Drug Allergy: No / Yes if yes, please indicate drug name/type of reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergy: No / Yes if yes, please indicate food/type of reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

G6PD: No / Yes / Unknown

Please circle where applicable:

Asthma Kidney problem Thyroid problem Hypertension Diabetes

Glaucoma Tuberculosis(TB) Liver problem Gastric problem Heart Disease

Cancer Epilepsy Bleeding disorders Anaesthetic problems Aids

If yes to above or other disorders please give more information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For ladies, are you pregnant: Yes/No/Unsure

Previous Hospitalizations/Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom should we thank for this referral: Google \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred mode of payment: Cash / Credit Card / Nets

Do you have medical insurance? No / Yes / Inpatient / Outpatient

If yes, which insurer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estimated date policy commenced \_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that the information provided is true and I also give consent to allow consultation and examination. I also acknowledge that any medicine can cause side effects. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature and date