

DK ♦ German Medical Diagnostic Center

Ansary Street 66 ♦ House 138 ♦ District 4
Zone 1 ♦ Kabul / Afghanistan
www.medical-kabul.com



Patient Registration Form

Please PRINT all Information

Last Name:										First Name:																								
Day of Birth (DD-MM-YYYY):										Sex:					Pregnant?					Age:					Height (cm):					Weight (kg):				
-										<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> NO <input type="checkbox"/> YES										cm					kg				
Nationality															Passport ID:																			
Employer:															Employer ID:																			
Work Phone:															Home Phone:																			
Are you taking any medications? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, please list them below: ↓															Email Address:																			
Medication															Dosage (mg)					Amount per day														
1.																																		
2.																																		
3.																																		
4.																																		
Are you allergic to something incl. any medication? If yes, please list them below: ↓															<input type="checkbox"/> NO <input type="checkbox"/> YES																			
Any other information you would like us to know? If yes, please list them below: ↓															<input type="checkbox"/> NO <input type="checkbox"/> YES																			

PATIENT AGREEMENT

I understand that payment is due at the time of service. I certify that the information provided on this form is correct. By virtue of my signature I authorize the DK-German Medical Diagnostic Center and any of its employees or other authorized personnel or to give me reasonable and proper medical care by today's standards.

! Please note that we destroy / delete all patient's documents / records after a period of 6 months. !

Date, Patients Signature:
