HealthFirst Medical Centre

PATIENT ADMISSION FORM

123 Wellness Avenue, Lisbon, Portugal | +351 210 000 000 | info@healthfirst.pt

*Please complete all fields in block capitals

1. PERSONAL INFORMATION

First Name *

Last Name *

Date of Birth (DD/MM/YYYY) *

Gender

National ID / NIF *

NHS / SNS Number

Home Address *

City *

Postal Code *

Country *

Phone Number *

Email Address

2. INSURANCE INFORMATION

Insurance Provider

Policy Number

GP / Family Doctor Name

GP Phone Number

3. MEDICAL HISTORY

Please tick any conditions that apply:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Asthma / Respiratory
- ☐ Allergies
- ☐ Cancer (current or past)
- ☐ Mental Health Condition
- ☐ Epilepsy
- ☐ Other

Current Medications (name and dosage)

Known Allergies (medication, food, other)

4. EMERGENCY CONTACT

Full Name *

Relationship to Patient *

Phone Number *

Email Address

5. CONSENT & SIGNATURE

- ☐ I consent to the medical treatment and examinations deemed necessary by the clinical team.
- ☐ I consent to the processing of my personal and medical data in accordance with GDPR.
- ☐ I consent to sharing relevant medical information with other healthcare providers involved in my care.

Patient Signature *

Date (DD/MM/YYYY) *