ASIAN HOSPITAL AND MEDICAL CENTER
Global Expertise. Filipino Heart.

PATIENT REGISTRATION FORM

* Please present any valid ID for Patient Identification
* Requires Passport for Non-Filipino Passport holders

ID PRESENTED:

☐Valid ID ________________ ☐Passport __________________

☐ Out Patient/ Day Surgery ☐ In-Patient Admission	ALLERGIES: TRAVEL HISTORY (Date, Country)

PATIENT INFORMATION

PATIENT LEGAL NAME: *Last Name* *First Name* *Middle Name*				HN: (to be filled up by Registration Staff)	
DATE OF BIRTH:	BIRTH PLACE:	NATIONALITY:	GENDER:	AGE:	RELIGION:
CIVIL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Widow/er	OCCUPATION:		NAME OF EMPLOYER and ADDRESS:		
PERMANENT ADDRESS:			MOBILE NUMBER: LANDLINE NUMBER:		EMAIL ADDRESS:
NAME OF FATHER:		MAIDEN NAME OF MOTHER		NAME OF SPOUSE:	
CONTACT PERSON IN CASE OF EMERGENCY:		RELATIONSHIP TO PATIENT:	MOBILE NUMBER: LANDLINE NUMBER:		EMAIL ADDRESS:

PATIENT PREFERENCES

ROOM OF CHOICE:	FOOD PREFERENCE: (Vegan, Halal, etc.)	ACCEPTANCE OF VISITORS: ☐ YES, will accept visitors ☐ NO visitors allowed

LEGAL AND FINANCIAL RESPONSIBILITIES

PERSON LEGALLY RESPONSIBLE TO PATIENT (NEXT OF KIN):	RELATIONSHIP TO PATIENT:	MOBILE NUMBER: LANDLINE NUMBER:	EMAIL ADDRESS:
MODE OF PAYMENT: ☐ Cash ☐ Credit Card ☐ HMO/Corporate Account ____________________ ☐ International Insurance ______________________	(IF SELF-PAY) PERSON RESPONSIBLE FOR THE BILLS: RELATIONSHIP TO PATIENT:	MOBILE NUMBER: LANDLINE NUMBER:	
PERSON AUTHORIZED TO CLAIM/REQUEST FOR BILL:	RELATIONSHIP TO PATIENT:	MOBILE NUMBER:	
PHILHEALTH NO.:	NAME OF MEMBER (If Dependent):	MEMBER CATEGORY: ☐ SELF-EMPLOYED ☐ INDIGENT ☐ LIFETIME/SENIOR ACT ☐ OFW ☐ EMPLOYED	
MEMBER'S EMPLOYER:	MEMBER'S DATE OF BIRTH:		

I am aware that I will be attended by a Philhealth Non-Accredited Doctor and that I will be the one responsible to pay for the corresponding Philhealth benefit amount not being covered by Philhealth Corp.

____
Signature over Printed Name

☐ *I hereby grant my full consent to the handling and processing of my and/or my dependent's/relative's personal/sensitive personal information to AHMC for the purpose set forth by this document.*

☐ *I hereby authorize AHMC and my treating doctor/s to release any of my and/or my dependent's/relative's medical or incidental personal information that may be necessary for medical evaluation, treatment, consultation or the processing of my insurance benefits.*

☐ *Confirming that I fully understood the above provisions and that all informations provided are true and correct.*

______________________________ Patient/Authorized Representative's Name (Signature over Printed Name)	Received by: ______________________________ Signature over Printed Name	Admission/Registration Processed by: ______________________________ Signature over Printed Name

QF-ADS-015
Rev.06
February 2020