Patient Data Entry Form

1. Personal Details

- **Full Name:** _____
- **Date of Birth (DD/MM/YYYY):** _____
- **Gender:** ☐ Male ☐ Female ☐ Other
- **Contact Number:** _____
- **Email Address:** _____

2. Address

- **Street Address:** _____
- **City:** _____
- **State/Province:** _____
- **Postal/Zip Code:** _____
- **Country:** _____

3. Medical Information

- **Primary Physician:** _____
- **Known Allergies (if any):**
  - _____
  - _____
- **Current Medications:**
  - _____
  - _____
- **Pre-existing Conditions (if any):**
  ☐ Diabetes ☐ Hypertension ☐ Asthma ☐ Other: _____

4. Emergency Contact

- **Name:** _____

- **Relationship:** _____

- **Contact Number:** _____

5. Insurance Information *(Optional)*

- **Insurance Provider:** _____

- **Policy Number:** _____

- **Group Number:** _____

6. Declaration

I confirm that the details above are true and consent to the use of this information for my medical care.

Signature: _____

Date: _____