



1484 Pollard Road, Suite 335 • Los Gatos • California • 95032 Phone: 408-866-8878  
Fax: 408.866-8878

### GENERAL INFORMATION

First Name	Middle Name	Last Name
Address		Date of Birth
City	State	Zip Code
Home Phone	Work Phone	Cell Phone

- I am over 18 years of age  
If you are registering someone other than yourself who is under 18  
 I am the Legal Guardian of the member I signed up  
If you are registering someone other than yourself who is over the age of 18  
 I am authorized to add, edit or delete the personal medical profile of the person on this record

### EMERGENCY INFORMATION

<b><u>PRIMARY CONTACT (below)</u></b>	<b><u>BLOOD TYPE (Optional)</u></b>	
Name	Relationship	
Home Phone	Work Phone	Cell/Other Phone
<b><u>SECONDARY CONTACT (below)</u></b>		
Name	Relationship	
Home Phone	Work Phone	Cell/Other Phone
<b><u>OTHER CONTACT (below)</u></b>		
Name	Relationship	
Home Phone	Work Phone	Cell/Other Phone

### ALLERGIES

Allergic	Notes
Allergic	Notes

### MEDICATIONS

<b><u>MEDICATION</u></b>	Condition Medication is Treating
Dosage	Frequency (How often do you take the Medication?)
Notes	
Prescribing Doctor	Doctor's Phone Number
<b><u>MEDICATION</u></b>	Condition Medication is Treating
Dosage	Frequency (How often do you take the Medication?)
Notes	
Prescribing Doctor	Doctor's Phone Number
<b><u>MEDICATION</u></b>	Condition Medication is Treating
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**MEDICATIONS**

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Dosage	Frequency (How often do you take the Medication?)
Notes	Notes
Prescribing Doctor	Doctor's Phone Number
<b><u>MEDICATION</u></b>	Condition Medication is Treating
Dosage	Frequency (How often do you take the Medication?)
Notes	Notes
Prescribing Doctor	Doctor's Phone Number

**NOTE: Please attach a list of any additional medication to the back of this form.**

**PHYSICIANS****DOCTOR'S NAME**

Doctor's Specialty

Condition being Treated

Phone Number

Address

City

State

Zip Code

Notes

**DOCTOR'S NAME**

Doctor's Specialty

Condition being Treated

Phone Number

Address

City

State

Zip Code

Notes

**HOSPITALS**

Hospital Name

Notes

Address

City

State

Zip Code

Phone Number

Contact Information

Hospital Name

Notes

Address

City

State

Zip Code

Phone Number

Contact Information

**INSURANCE****PRIMARY INSURANCE**

Insurance Provider Name

Type of Insurance

Medical Record Number

Group/I.D. No.

Contact Information

Phone No.

**SECONDARY INSURANCE**

Insurance Provider Name

Type of Insurance

Medical Record Number

Group/I.D. No.

Contact Information

Phone No.

**IMMUNIZATIONS**

Immunization Name/Type

Date of Immunization

Next Due (if known)

Immunization Name/Type

Date of Immunization

Next Due (if known)

Immunization Name/Type

Date of Immunization

Next Due (if known)

**SURGERIES**

Elective or Non-Elective

Name/Type

Surgery Date

Notes

Elective or Non-Elective

Name/Type

Surgery Date

Notes

Elective or Non-Elective

Name/Type

Surgery Date

Notes

## MEDICAL HISTORY

<input type="checkbox"/> Abdominal Pain _____	<input type="checkbox"/> Gall Bladder Trouble _____	<input type="checkbox"/> Pneumonia _____	<input type="checkbox"/> Chicken Pox Polio Mumps _____
<input type="checkbox"/> Allergies/Hayfever _____	<input type="checkbox"/> Gout _____	<input type="checkbox"/> Prostate Disease _____	<input type="checkbox"/> Measles <input type="checkbox"/> Rubella _____
<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily _____	<input type="checkbox"/> Hair Loss _____	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema _____	<input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Ankle - Swollen _____	<input type="checkbox"/> Headaches - Frequent _____	<input type="checkbox"/> Rashes <input type="checkbox"/> Hives _____	<input type="checkbox"/> Herpes _____
<input type="checkbox"/> Appetite - Loss of _____	<input type="checkbox"/> Heart Murmur _____	<input type="checkbox"/> Sexual/Menstrual Dysfunction _____	<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> Arthritis/Rheumatism _____	<input type="checkbox"/> Hemorrhoids _____	<input type="checkbox"/> Sinus Trouble _____	<input type="checkbox"/> Females - Please Complete _____
<input type="checkbox"/> Asthma/Wheezing _____	<input type="checkbox"/> Hernia _____	<input type="checkbox"/> Stools - Bloody or Tarry _____	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No _____
<input type="checkbox"/> Back Pain - Recurrent _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Stroke _____	Planning Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No _____
<input type="checkbox"/> Bone Fracture/Joint Injury _____	<input type="checkbox"/> Indigestion or Heartburn _____	<input type="checkbox"/> Swallowing Difficulty _____	Menstrual Flow _____
<input type="checkbox"/> Bowel Habits - Change in _____	<input type="checkbox"/> Infections - Frequent _____	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps _____
<input type="checkbox"/> Bronchitis/Chronic Cough _____	<input type="checkbox"/> Jaundice/ Hepatitis _____	<input type="checkbox"/> Throat - Sore - Frequent _____	____ Days of Flow ____ Length of Cycle _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Kidney Stones _____	<input type="checkbox"/> Thyroid Disease _____	Date - 1st day of late period _____
<input type="checkbox"/> Chest Pain _____	<input type="checkbox"/> Lactose Intolerance _____	<input type="checkbox"/> Tremor / Hands Shaking _____	<input type="checkbox"/> Pain / Bleeding during or after sex _____
<input type="checkbox"/> Convulsions / Seizures _____	<input type="checkbox"/> Leg Pain - Walking _____	<input type="checkbox"/> Ulcers - Peptic _____	Number of: _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Memory Loss _____	<input type="checkbox"/> Urethral Discharge _____	____ Pregnancies ____ Abortions _____
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation _____	<input type="checkbox"/> Mental Illness _____	<input type="checkbox"/> Urination <input type="checkbox"/> Overnight > Than Twice _____	____ Miscarriages ____ Live Births _____
<input type="checkbox"/> Diphtheria _____	<input type="checkbox"/> Moodiness - Excessive _____	<input type="checkbox"/> Decrease in Force/Flow _____	Birth Control Method _____
<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's/Colitis _____	<input type="checkbox"/> Muscle Weakness _____	<input type="checkbox"/> Painful <input type="checkbox"/> Loss of Control _____	B.C. Pill (Name) _____
<input type="checkbox"/> Dizziness / Fainting _____	<input type="checkbox"/> Nausea / Vomiting - Persistent _____	<input type="checkbox"/> Urine - Blood In _____	<input type="checkbox"/> Flushing / Menopause _____
<input type="checkbox"/> Ear Infections - Frequent _____	<input type="checkbox"/> Nervousness <input type="checkbox"/> Depression _____	<input type="checkbox"/> Varicose Veins / Phlebitis _____	Date of last PAP Test _____
<input type="checkbox"/> Ear - Ringing In _____	<input type="checkbox"/> Nose Bleeds _____	<input type="checkbox"/> Venereal Disease _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
<input type="checkbox"/> Eye Infections _____	<input type="checkbox"/> Numbness / Tingling Sensations _____	<input type="checkbox"/> Vision - Failing _____	Date of Last Mammogram _____
<input type="checkbox"/> Fatigue - Chronic _____	<input type="checkbox"/> Osteoporosis _____	<input type="checkbox"/> Weight Loss - Recent _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
<input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet _____	<input type="checkbox"/> Phobias _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

## FAMILY HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## HABITS

Alcohol: Type _____	Diet: Salt Intake _____	Sleep: Difficulty Falling Asleep ____	Smoke: Packs Daily _____
Amount _____	Fat Intake _____	Continuity Disturbances _____	How Long _____
Coffee: Cups Daily _____	Other _____	Early Morning Awakening _____	Interested in Stopping? _____
Other Caffeine _____	Exercise Routine: _____	Daytime Drowsiness _____	

## MONTHLY Automatic Electronic Payment/Draft Authorization

By using the authorization form below, you can choose Monthly Automatic Electronic payment method. The Plan will draw a check on your personal checking account each month. You no longer have to worry about late payment charges or paperwork.

I/We hereby authorize World Health Plan.org to charge my account each month the amount shown below, said amount to be credited to my account with World Health Plan.org. This authority is to remain in full force and effect until notified in writing to World Health Plan.org of termination. The named bank below is authorized to make corrections should any be necessary)

**PLEASE PRINT AND COMPLETE FORM BELOW**

Name \_\_\_\_\_  
 Monthly Plan \_\_\_\_\_  
 Please check one  Single \$7.00  Couple \$10.00  Family \$12.00

Name on Bank Account \_\_\_\_\_  
 Name of Bank \_\_\_\_\_ Phone Number \_\_\_\_\_ Contact \_\_\_\_\_

BANK USE: \_\_\_\_\_

WFI ACCT. #	TRANSACTION CODE

ACCOUNT NO. INFORMATION -Applicant

**Place an "X" here \_\_\_\_\_ to indicate "I agree" with the automatic Electronic payment/Draft Authorization indicated above.**

### MAIL WITH PAYMENT TO WHP.org (Please Print)

NAME \_\_\_\_\_  
Last First Initial  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
 PHONE (Bus) ( ) \_\_\_\_\_ (Res.) ( ) \_\_\_\_\_

Covered dependents – List Eligible Dependents (Same Residence)

SPOUSE \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Initial  
 CHILDREN \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Initial  
 \_\_\_\_\_ Birthdate \_\_\_\_\_  
 \_\_\_\_\_ Birthdate \_\_\_\_\_

Charge:  Visa  Mastercard  Discover  Am. Ex. Expiration:

--

AGENT # \_\_\_\_\_ Date \_\_\_\_\_

A1	A2	A3	A4	A5	GRP#

**MAKE CHECK PAYABLE TO:**

World Health Plan.org  
 MAIL TO:  
 World Health Plan.org  
 1484 Pollard Rd., Ste.335  
 Los Gatos, CA 95032

COST .....	ANNUAL	MONTHLY
<input type="checkbox"/> INDIVIDUAL .....	\$60	\$7
<input type="checkbox"/> COUPLE .....	\$80	\$10
<input type="checkbox"/> FAMILY .....	\$95	\$12

**Put an "X" here \_\_\_\_\_ to indicate "I agree" to enroll in this plan with the understanding it is for a minimum of 12 months.**