

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____
Last First Middle

Address: _____
Unit/Apt#/Street Name City Province Postal Code

Home Phone#: () Work Phone#: () Mobile Phone#: ()

E-mail Address: _____ Gender: _____ Occupation: _____

Date of Birth: ____ / ____ / ____ Health Card #: _____ Version Code: _____
D M Y

Emergency Contact: _____ Relationship: _____ Phone#: ()

Previous Family Physician: _____ Phone#: ()

MEDICAL HISTORY

Please check all that apply:

____ heart attack ____ heart disease ____ high blood pressure ____ diabetes
____ stroke ____ seizures ____ depression/anxiety ____ asthma
____ emphysema (COPD) ____ tuberculosis ____ cancer (type: _____) ____ HIV
____ other (details: _____)

Operations: _____

Medications being taken: _____

Family History of Significant Medical Illness: _____

Any known Drug Allergies? Y N If Yes, what _____

Do you have a Latex Allergy? Y N

PLEASE NOTE THIS IS NOT A LATEX FREE ENVIRONMENT.

BY SIGNING THIS FROM, I HEREBY CERTIFY THAT I UNDERSTAND THE FOLLOWING:

1) THIS IS A FAMILY PRACTICE AND DUE TO THE NATURE OF THIS TYPE OF PRACTICE, IT IS MY RESPONSIBILITY TO FOLLOW UP WITH THE CLINIC REGARDING ALL BLOOD WORK AND OTHER TEST RESULTS AND ANY REFERRAL APPOINTMENTS MADE ON MY BEHALF.

2) ALL NON-INSURED SERVICES MUST BE PAID FOR PRIOR TO SEEING THE PHYSICIAN. A SCHEDULE OF FEES IS AVAILABLE FROM RECEPTIONIST STAFF; AND

3) I CONSENT TO THE RELEASE OF MY MEDICAL RECORDS TO MY PREVIOUS FAMILY PHYSICIAN.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____