Patient Registration Form

Patient Name _____ _____ Sex _____
Last First

Date of Birth (Year) _____ (Month) _____ (Day) _____ Age _____

Health Card Number _____ Version Code _____ Expiry Date _____

Address _____
Apt Number Street Name City Postal Code

Contact Number (Home) _____ (Cell) _____ (Work) _____

Email Address _____ Occupation _____

Emergency Contact _____ Relation _____

Do you have medical insurance? Yes / No
Name of Medical Insurance Company _____

MEDICAL HISTORY
Reason for visit _____

Any Allergies (1) Medications _____
(2) Other _____

Current Medical Illness _____
_____

Past Surgeries _____
_____

List of current medications _____
_____

Do you have a family physician? Yes / No
Family Physician's Name _____
Are you up to date on your immunizations? _____

_____
Patient/Guardian Signature Consent to Treatment Date