PATIENT REGISTRATION

Today's Date:(Day/Month/Year):_____

Full Name: (Mr ☐ Miss ☐ Mrs ■ Ms ☐ Dr)_____

I prefer to be addressed as:_____

Date of Birth (Day/Month/Year):_____

Home Address: _____

City: _____

Postal Code: _____

Cell Phone : _____

Home Phone: _____

Work Phone: _____

e-mail : _____

I prefer to be contacted by: ☐ cell phone ☐ home phone ☐ work phone ☐ e-mail

Health Card Number: _____

Pharmacy: _____ Phone: _____

How did you find out about our office: referred by _____

convenient location ☐ website ☐ other ☐ _____

In case of emergency we should notify: _____

Relationship to you: _____

Phone Number : _____

Your Family Doctor: _____ Phone: _____

Medical Specialist (1): _____ Phone: _____

Medical Specialist (2): _____ Phone: _____

Primary Insurance Provider:(if applicable)_____

Policy Number: _____

Identification Number: _____

Secondary Insurance Provider:(if applicable)_____

Policy Number:_____

Identification Number: _____