PATIENT REGISTRATION FORM

Patient Name (Last) (First) (Middle name)

Gender: _____ Date Of Birth:_____ Age:_____

Health Card Number: _____ Version Code: _____ Expiry Date:_____

Address: (Street Number) (Apt. Number) (City) (Postal Code)

Mother/Guardian_____ Home phone(___)_____Cellphone(___)_____

Father/Guardian_____ Home Phone(___)_____Cellphone_(___)_____
E-mail:_____

EMERGENCY CONTACT

Name:_____ Phone Number:_____

Relationship to the patient:_____

MEDICAL HISTORY

Reason Today's Visit:_____

Allergies:_____

Current Medical Illness:_____

Past Medical Illness:_____

Past Surgery (ies):_____

List Of Current Medication(s)_____

Do You Have A Family Physician? Yes/No: Physician Name:_____

Are You Up-To-Date on Your Immunization? Yes/No

I hereby agree the above past and current medical information is true and accurate to the best of my knowledge.

_____ _____

Patient's/Parent's/Guardian's Signature Date