Fax: 403- 452- 3381

PATIENT INFORMATION & REGISTRATION FORM
(PLEASE PRINT)

PREFERRED LOCATION: CALGARY DEERFOOT MALL

Patient's Last Name: _____ First Name:_____

Email: _____ Preferred Name: _____

Middle Name: _____Initial: _____ Mr. / Mrs. / Miss / Ms
(Please Circle One)

Birth Date : Day_____Month_____Year_____ Age_____Sex: M or F

Marital Status (Please Circle One) Single/ Married/ Divorced /Separated /Widowed

Health Care Number _____

Is this an Alberta Health Care Number? Yes / No
Province:_____

Street Address: _____

City: _____

Province: _____ Postal Code: _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____

Your Occupation: _____

Spouse/Parent/Guardian's Name _____ Relation: _____

How did you hear about our clinic? _____

Preferred Pharmacy? _____

PATIENT SIGNATURE _____ DATE:_____

PLEASE FAX T0 403- 452- 3381