



Fax: 403-452-3381

**PATIENT INFORMATION & REGISTRATION FORM
(PLEASE PRINT)**

PREFERRED LOCATION: CALGARY ERINWOOD PLAZA

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 TO 403-452-3381