



Fax: 403- 452- 3381

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

**PREFERRED LOCATION: CALGARY SAGE HILL**

**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**