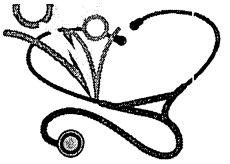

REGISTRATION FORM

(Please Print)

Today's Date: | Office use only :

PATIENT INFORMATION

Patient's last name: | First: | Middle: | Mr. ○ Mrs. ○ | Miss ○ Ms. ○ | Marital status: Single ○ Mar/CL ○ Div ○ Sep ○ Wid ○

Health card | VC | EXP | Home phone : ( ) | Birth date: | Age: | Sex: M ○ F ○

Street address: | P.O. box: | City: | Municipality:

Postal Code: | Occupation: | Employer:

Next of Kin Name: | Phone:

Pharmacy of choice: | Insurance plan: Private ○ ODB ○ None ○

Do you currently have a family doctor or nurse practitioner No ☐ if so where?

MEDICAL HISTORY

Drug or environmental allergies :

Are you pregnant No ☐ if so what is your due date?

Do you currently have or were you ever diagnosed with:

Diabetes ☐	Cancer, Specify type:
High blood pressure ☐	Asthma or COPD ☐
Arthritis ☐	Other:
Heart disease ☐	Other:

Past surgeries:

MEDICATIONS

(Please list ALL vitamins/minerals, herbal, prescribed, and over the counter medications-even if just taken occasionally)

Patient/Guardian signature | Date

Save