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:__________________

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