NEW PATIENTS INFORMATION & REGISTRATION FORM

(Please fill in, Print and Fax)

Patient's Last Name: _____

First Name:_____

Middle Name: _____

Birth Date : Month_____ **Day**_____ **Year**_____

Sex: M or F (Please circle one)

Alberta Health Care Number _____

If not Alberta Health Care, Province Name :_____

Street Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Home Phone # _____ **Cell Phone #** _____

Work Phone # _____

PATIENT/ Guardian SIGNATURE _____

Relation: _____ **DATE:**_____

PLEASE FAX COMPLETED FORM T0: 289-521-8845

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