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)

Ontario Health Insurance Plan Number _____________________________

If Do not have Ontario Health Insurance, 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

Unit 105A 400 Dundas St. E.
Phone: 289-51-8844 Fax: 289-5218845
www.medxclinic.ca