PATIENT NUMBER

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____
Day/Month/Year

HOW WOULD YOU LIKE TO BE ADDRESSED? : _____ ADULT ☐ CHILD ☐

Patient Information

Address: _____

_____

City: _____ Postal Code _____

Home Phone No.: _____

Bus Phone No.: _____

Cell Phone No.: _____

Email address: _____

Social Insurance No.: _____

Method of Payment: _____

Cheque ☐ Drivers License #_____

Cash ☐ Credit Card ☐

Referred by: _____

Do you have any relatives who are patients of this practice?

_____

In case of an emergency, contact:

Name: _____

Relationship: _____

Phone No.: _____

Insurance Information

Primary Coverage:

Employee Name: _____

Employee Birth date: _____

Employer: _____

Name of Insurance Co.: _____

Group/Policy No.: _____

I.D./Certificate No.: _____

Employee Social Insurance No.: _____

Secondary Coverage:

Employee Name: _____

Employee Birth date: _____

Employer: _____

Name of Insurance Co.: _____

Group/Policy No.: _____

I.D./Certificate No.: _____

Employee Social Insurance No.: _____

Registration

HEALTH ALERT