Once this form is completed, please email to royalcolumbiamedicalclinic@outlook.com and we will email you with your initial meet and greet appointment.

ROYAL COLUMBIA MEDICAL CLINIC/ NEW PATIENT REGISTRATION FORM

ACCEPTING NEW PATIENTS: TICK CHECKBOX TO BOOK WITH ONE OF THE FOLLOWING PHYSISCIANS/NURSE PRACTIONERS.

- ❑ ***Dr. Tri (Chris) Doan***
- ❑ ***Dr. Abhineet Garg***
- ❑ ***Melanie Allen (Nurse Practioner)***

Date: _____

CONTACT INFORMATION:

First name: _____ Last name: _____

Preferred Name: _____

Date of Birth: _____ /_____ / _____
Day Month Year

- ❑ ***F***
- ❑ ***M***
- ❑ ***Other: _____***

BC Health Care Number: _____

Address: _____City: _____

Province: _____ Postal Code: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____Email address: _____

Occupation: _____Employer: _____

PERSON/NEXT OF KIN:

First and Last name: _____ Phone: _____

Relationship to Next of Kin: _____

- ❑ ***SPOUSE (if applicable) TICK CHECKBOX ONLY IF SPOUSE IS OR WILL BE A PATIENT AT ROYAL COLUMBIA MEDICAL CLINIC***

Name: _____ Date of Birth: _____

***PHN: _____* Email address: _____**

Cell Phone: _____ Work Phone: _____

- ❑ ***CHILDREN (living at home): <u>TICK CHECKBOX ONLY IF CHILD IS OR WILL BE A PATIENT AT ROYAL COLUMBIA MEDICAL CLINIC</u>***

Name: _____ Date of Birth: _____ PHN: _____

Name: _____ Date of Birth: _____ PHN: _____

Name: _____ Date of Birth: _____ PHN: _____

Name: _____ Date of Birth: _____ PHN: _____

- ❑ **PARENTS (If patient is under 20yrs old): _____Phone: _____**

<u>Tick if parent NOT a patient at Royal Columbia Medical Clinic</u>

Preferred Pharmacy Name & Address: _____

Previous Family Doctor: _____