Patient Registration

First Name:______________________________ **Last Name**:___________________________

Preferred Name -if different than above:____

Address:____

City:________________________________ **Postal Code**:_____________________________

Preferred Phone #:___________________________________ home/cell/work (circle)

Alternate Phone #:____________________________home/cell/work

Email:____

Date of birth:________/_________/__________(dd/mm/yyyy) **Sex**: M or F (select one)

Driver's License /Health Card #:________________________________

*****IF YOU HAVE YOUR INSURANCE CARD/S, YOU MAY*****
*****PRESENT THEM INSTEAD OF FILLING OUT THIS PORTION*****

Primary Insurance Information:

Name of Insured: _________________________________**Insured Date of Birth**:_________/_________/___________(dd/mm/yyyy)

Insurance Company:________________________________

Employer:____ **Employer Phone**:_______________________________________

Policy/Group #:____________________________________**ID/Certificate #**:____

Relationship to Insured: Self Spouse Common Law Spouse Child Other (please specify)

Secondary Insurance Information:

Name of Insured: _________________________________**Insured Date of Birth**:_________/_________/___________(dd/mm/yyyy)

Insurance Company:_________________________________

Employer:____ **Employer Phone**:_______________________________________

Policy/Group #:____________________________________ **ID/Certificate #**:____

Relationship to Insured: Self Spouse Common Law Spouse Child Other (please specify)