PAGDIN HEALTH
LIVING LONGER BETTER
Dr. G. Pagdin Inc.

Registration Form

Name: _____ **Date:** _____

B.C. Medical #: _____

Birth Date (MM/DD/YYYY): _____

Address: _____

Please check your primary contact number.

☐ Home Phone: _____

☐ Cell Phone: _____ ☐ Work Phone: _____

Family Physician: _____

Do you want your family physician to be kept informed of your progress? ☐ Yes ☐ No

Occupation: _____

May we add your email to our Health Living Newsletter list? ☐ Yes ☐ No

E-mail Address: _____

May we communicate with you via email correspondence? ☐ Yes ☐ No

E-mail Address: _____

Emergency Contact Name: _____
. Number: _____

Allergies: _____

How did you hear about us? _____

We require 24 hours notice for any appointment cancellations or a $100.00 fee will be charged. Payment will be required prior to scheduling additional appointments.

Lab results must be received to our office a minimum of 1 week prior to your scheduled appointment or your appointment will be rescheduled. For this reason, we suggest you get your lab work done 2 weeks prior to your appointment date.

I agree to the above policies. Signature: _____