Registration Form

Name (Last, First) : ____________________________________ **Date:** ______________________

Provincial Medical #: ______________________________ **Male / Female (circle)**

Birth Date (MM/DD/YYYY): _________________

Address: __________________________________ **Postal Code:** _________________

City: ______________________________________

✓ **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: ___________________________________

E-mail Address: ________________________________

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

Emergency Contact Name: ______________________

. Number: ____________________

Allergies: ______________________________________ or ☐ **No Known Allergies**

How did you hear about us? _________________________________ **If from a friend or family member, may we ask whom it was?** ____

*We ***require*** a notice of 24 hours for any procedure appointment cancellations. If not received, a cancellation fee of $500 is charged. **REQUIRED:** ☐ I have read the above and agree to policy.