PAGDIN HEALTH
LIVING LONGER BETTER

Registration Form – Vancouver Location

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 48 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.