PAGDIN HEALTH
LIVING LONGER BETTER

Registration Form

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

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

Birth Date (MM/DD/YYYY): _________________

Address: __________________________________ **Postal Code:** _________________

City: ______________________________________

✓ **Please check your preferred method of contact.**

☐ Home Phone: ______________________
☐ Cell Phone: ________________________
☐ Work Phone: _______________________

E-mail Address: ______________________________________

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

Family Physician: _____________________________

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

Occupation: ___________________________________

Emergency Contact Name: ______________________
. Number: ____________________

Allergies: _______________________________________ or ☐ **No known allergies**

Medications:____

____

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 appointment cancellations. If not received, a cancellation fee of $60 is charged. REQUIRED: ☐ I have read the above and agree to policy.**