PAGDIN HEALTH
LIVING LONGER BETTER
Dr. Grant Pagdin, MD
WWW.PAGDINHEALTH.COM

Registration Form – Bio-Identical Hormone Replacement

Name: ____ **Date:** ____________________

Health Card Number: _________________________ **Male** | **Female** (please circle)

Birth date (DD-MM-YYYY): __________________

Address, City, Postal Code: ____

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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 or No **(circle your reply)**

Occupation: ____

Email Address: ____

May we add your email to our Health Living Newsletter list? Yes or No **(circle your reply)**

May we communicate with you via email correspondence? Yes or No **(circle your reply)**

Emergency Contact **Name:** __________________________________

Number: _________________________________

Allergies: ____

Medications: ____

Supplements: ____

How did you hear about us? ____

We require 24hrs notice for any appointment change/cancellation or a No-Show Fee may be applied ($100). Payment will be required prior to scheduling additional appointments.

Lab results must be received to our office a minimum of 5 full business days prior to your appointment or your appointment will be rescheduled. For this reason, we suggest you have your lab work done a minimum of 2 weeks prior to your appointment date.

I agree to the above policies. Signature: ____