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

Registration Form – Executive Clients

Name: _____ **Date:** _____

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

Birth date (DD-MM-YYYY): _____

Address, City, Postal Code: _____

_____

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: _____