

Registration Form – Procedures

Name: _____ Date: _____

Personal Health Number: _____ (required to set up your chart as on occasion
Dr. Pagdin will need to request further lab testing and/or diagnostic imaging)

Male | Female (circle one)

Birth date (DD-MM-YYYY): _____

Address, City, Postal Code: _____

Please check your primary contact number

Home Phone: _____ Cell Phone: _____
 Work Phone: _____

Family Physician: _____ City/Town: _____

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: _____

How did you hear about us? _____

Lifestyle

Do you smoke? No, never have No, quit at the age of _____, started at age _____

Yes, how often? _____ How long have you smoked? _____

How often do you drink alcohol? _____ Alcohol type(s): _____

How often do you exercise? _____ Type(s) of exercise: _____

Do you abide by a special diet? No Yes

If yes, what type? (Vegan, Celiac, etc.)

Allergies: _____

Medications: _____

Supplements: _____

Past Medical History:

- Heart Disease/Heart Attack
- High Cholesterol
- High/Low Blood Pressure
- Diabetes
- Thyroid Disease (Grave's/Hashimoto's/Hypo/Hyper/Unknown)
- Deep Vein Blood Clots
- Stomach Ulcers
- Cancer: _____
- Liver Disease
- Kidney Disease
- Stroke
- Asthma/COPD
- Irritable Bowel Syndrome
- Crohn's or Ulcerative Colitis
- Celiac Disease
- Other: _____

Surgical History

List any past surgeries:

Date of surgery:

We require 48hrs notice for any appointment change/cancellation or a No-Show Fee may be applied (\$200-\$500 depending on the procedure booked). Payment will be required prior to scheduling additional appointments.

I agree to the above policies. Signature: _____