DALHOUSIE MEDICAL CARE

Family Practice | Walk In | Lab on site

New Patient Registration Form

PERSONAL INFORMATION:

Last Name: _____ First Name: _____

Middle Name: _____ DOB(mm/dd/yy)_____

Sex: Male___ Female___ Other___

Health Card No:_____ Version Code:_____ Expiry(mm/dd/yy)_____

Address:_____

City:_____ Province: _____ Postal Code: _____

Phone (H):_____ Phone (C):_____ Phone (W):_____

Family Doctor:_____ Phone: _____

MEDICAL INFORMATION:

Allergies:

_____

Current Medications:

_____

Medical History:

_____

_____

EMERGENCY CONTACT INFORMATION:

First Name:_____ Last Name:_____

Contact No:_____ Relation: _____

Signature:_____ Date: _____

Once completed, please email the form to info@dalhousiemedicalcare.ca!

P: 647-345-2992
F: 647-345-7992
info@dalhousiemedicalcare.ca
www.dalhousiemedicalcare.ca