WOODVIEW MEDICAL CLINIC

ID#

Woodview Medical Clinic
Patient Information Sheet

NAME: _____ SEX: M_____F _____
(FIRST) (LAST)

ADDRESS:_____CITY: _____

PROV:_____POSTAL CODE: _____

TELEPHONE NUMBER: HOME:_____CELL: _____

DATE OF BIRTH:_____
(DAY) (MONTH) (YEAR)

HEALTH CARD NUMBER:_____VERSION CODE:_____

EMAIL:_____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

SIGNIFICANT PAST MEDICAL HISTORY:_____

EMPLOYER'S NAME: _____

TEL.#:_____ADDRESS:_____

DO YOU HAVE A REGULAR FAMILY DOCTOR? Y_____N _____

NAME:_____

ADDRESS:_____

ARE YOU LOOKING FOR A REGULAR FAMILY DOCTOR? Y_____N_____

HOW DID YOU HEAR ABOUT OUR CLINIC?: _____

_____

_____

Thank you for your cooperation.