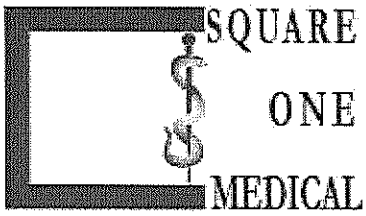

Family Practice & Walk-In Clinic

PATIENT REGISTRATION FORM

DATE.....E-MAIL.....

PATIENT: LAST NAME: .....

FIRST NAME: .....

DATE OF BIRTH (dd/mm/yyyy): .....SEX: .....

ADDRESS: .....APT:.....

CITY: .....PROVINCE: .....

POSTAL CODE: .....

PROFESSION: .....

PHONE# (PRIMARY):.....

PHONE# (SECONDARY): .....

HEALTH CARD #: .....VERSION CODE: .....

FAMILY DOCTOR: .....

MEDICATIONS: .....

ALLERGIES: .....

SIGNATURE OF PATIENT (or Parent/guardian)

.....

If not parent or guardian please specify relationship to patient

4175 Confederation Parkway * Units 1 & 2 * Mississauga * ON. * L5B 0H1
P: (905)848-4880 * F: (905) 848-4882