BRADFORD MEDICAL CENTER

NEW PATIENT REGISTRATION FORM

DATE: _____

PATIENT'S NAME: LAST _____ FIRST _____

DATE OF BIRTH : _____ SEX: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK/CELL PHONE: _____

OHIP#: _____

FAMILY DOCTOR: _____

OCCUPATION: _____

EMAIL: _____

ALLERGIES: _____

PATIENT CURRENT MEDICAL ISSUES: _____

PATIENT CURRENT MEDICATIONS: _____

EMERGENCY CONTACT: _____

HOME PHONE: _____ WORK/CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE (PATIENT OR GUARDIAN): _____

NAME OF GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____

KINDLY FILL IT OUT & BRING BACK TO CLINIC