Patient registration form

Type into this form or write by hand. Attach an extra sheet if you need more space.

Patient information

Last name

First name

Name you go by (optional)

Pronouns (optional)

Date of birth (YYYY-MM-DD)

Personal health number

Sex (female / male)

Street address

City

Postal code

Contact phone

Alternate phone

Email

Emergency contact name

Emergency contact phone

For pediatric patients

Parent 1 name

Parent 2 name

Parent 1 address

Parent 2 address

Parent 1 city and postal code

Parent 2 city and postal code

Parent 1 contact phone

Parent 2 contact phone

Medical problems

Condition	Date of diagnosis

Previous surgeries or procedures

Surgery or procedure	Date of procedure

Return both pages in person or fax to 604-479-0139.

Questions? Call reception at 604-479-0137. Please keep completed forms out of email.

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Use the space below or attach a medication list or additional history with your form.

Medication list

Name	Strength	Directions for use

Medical allergies

Over-the-counter medications taken regularly

Tobacco, alcohol and substance use

Do you chew tobacco?	Y / N		How often?	
Do you smoke cigarettes?	Y / N		How many times per day?	
Do you drink alcohol?	Y / N		How often?	
Substance use history?	Y / N		Please explain.	

For female patients

Last Pap smear (ages 25 to 70)

Last mammogram history (ages 40 to 75)

Vaccination history

Vaccine name	Date

For patients aged 50 and over

Have you had fecal testing for bowel cancer? (Y / N)

Date of last sample

Any other information we should know

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