



MEDICAL Tree

Patient Registration Form

Patient Name _____ Sex _____
Last First

Date of Birth (Year) _____ (Month) _____ (Day) _____ Age _____

Health Card Number _____ Version Code _____ Expiry Date _____

Address _____
Apt Number Street Name City Postal Code

Contact Number (Home) _____ (Cell) _____ (Work) _____

Email Address _____ Occupation _____

Emergency Contact _____ Relation _____

Do you have medical insurance? Yes / No

Name of Medical Insurance Company _____

MEDICAL HISTORY

Reason for visit _____

Any Allergies (1) Medications _____