Primary Care Naturopathic Clinic

REGISTRATION FORM

Today's date:					
PATIENT INFORMATION					
Patient's last name: First: Middle:					Date of Birth: day/month/year / /
Age:	Sex:	Occupation:		Current Physician:	
Street address:		Apartment #:		City:	
Province:	Postal code:		Best phone no.:	Other phone no.:	
Chose clinic because/Referred to clinic by :					
❑ Dr.	❑ Family	❑ Friend	❑ Close to home/work	❑ Internet Social Media	❑ Other
Other family members seen here:					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Primary Care Clinic. I understand that I am financially responsible for any balance. I also authorize Primary Care Clinic or insurance company to release any information required to process my claims.

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Patient/Guardian name (if under 18 years of age) Signature Checkbox Date