



Phone: 587-779-8887 Fax: 587-747-0180

**PATIENT INFORMATION & REGISTRATION FORM  
(PLEASE PRINT)**

**PREFERRED LOCATION: CALGARY TEMPLE**

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Initial: \_\_\_\_\_ Mr. / Mrs. / Miss / Ms  
(Please Circle One)

Birth Date : Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Age \_\_\_\_\_ Sex: M or F

Marital Status (Please Circle One) Single/ Married/ Divorced /Separated  
/Widowed

Health Care Number \_\_\_\_\_

Is this an Alberta Health Care Number? Yes / No

Province: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Your Occupation: \_\_\_\_\_

Spouse/Parent/Guardian's Name \_\_\_\_\_ Relation: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Preferred Pharmacy? \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE FAX TO 587-747-0180**