
10520 Yonge Street, Unit 4, Richmond Hill, ON. L4C 3C7
905-883-6067

# Patient Information Form

*Last name* _____

*First name* _____

*Sex* *Male (  ) Female (  ) Other (  ). Please specify* _____

*Date of Birth* *Year* _____ *Month* _____ *Year* _____

*Address* _____ *Unit* _____

*City* _____ *Postal Code* _____

*Home Phone* _____ *Cell Phone* _____

*Preferred number for contact* _____

*Email Address* _____

*Health Card Number* _____ *Version Code* _____

*Allergies* *(1)* _____

*(2)* _____

*(3)* _____

*(4)* _____

*Reason for visit* _____

_____

_____

_____
*Name of patient / parent / guardian (PRINT)*

_____
*Signature*

_____
*Date*

*Office Use / Comments*