Oshawa Medical Institute

PATIENT REGISTRATION FORM

Patient Name _____ Sex _____

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 _____

Pharmacy Name and Location_____

MEDICAL HISTORY

Reason for visit _____

Any Allergies (1) Medications _____ (2)

Other _____

Current Medical Illness _____

_____

Past Surgeries/ Medical History

_____ Do

you have a family physician? Yes / No Family Physician's Name _____

Are you up to date on your immunizations? _____

Signature of Patient/Guardian_____ Date_____