Vcarepoint
MEDICAL
CARE YOU CAN COUNT ON

# NEW PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Preferred Name _____ Date of Birth (DD/MM/YYYY) _____ Sex ☐ Male ☐ Female ☐ X ☐ Prefer Not To Answer

Health Card Number _____ Version Code _____ Expiry Date (DD/MM/YYYY) _____

## HOME ADDRESS

Street Address _____ Unit Number _____

City _____ Province _____ Postal Code _____

## CONTACT INFORMATION

Home Phone _____ Cell Phone _____ Work Phone _____ Email Address _____

Preferred Contact Method ☐ Phone ☐ Cell ☐ Email ☐ No Preference

## EMERGENCY CONTACT

Name _____ Relationship _____ Phone Number _____

## PREFERRED PHARMACY

Pharmacy Name _____ Pharmacy Address _____

Phone Number _____ Fax Number (if known) _____

## PREVIOUS FAMILY PHYSICIAN

Physician Name _____ Clinic Name _____

Phone Number _____ Fax Number _____

## CONSENT TO CONTACT

I consent to VCarepoint Medical Clinic contacting me regarding appointments, test results, referrals, and administrative matters using the contact information provided above. ☐ Yes ☐ No

## PATIENT DECLARATION

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I understand that it is my responsibility to notify the clinic of any changes to my contact information or health insurance coverage.

Patient Signature _____ Date (DD/MM/YYYY) _____

**OFFICE USE ONLY**

Patient ID _____ Avaros Chart Created ☐ Yes ☐ No Health Card Verified ☐ Yes ☐ No

Registration Completed By _____ Date (DD/MM/YYYY) _____

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