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PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY

SURNAME: _____ FIRST NAME: _____
MIDDLE NAME: _____ **PREFERRED NAME:** _____

SEX: M _____ F _____

DATE OF BIRTH: _____/_____/_____
D / M / YR

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

EMAIL: _____

HEALTH CARD # _____ VERSION CODE **(VC):** _____
(Initials after the # on your card)

EXPIRY DATE: _____

HOME #: _____ BUSINESS #: _____
CELL #: _____ OTHER: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____
PHONE: _____

REFERRED BY: _____