ASSOCIATE PEDIATRICS CLINIC
YYCPEDIATRICS.COM

Gulf Canada Square
Suite 340, 401 – 9 Avenue SW
Calgary, AB T2P 3C5
Ph: 403-221-4434 Fax: 403-221-4466

B. C. Ross, MD, FRCPC
C. Gilman, MD, FRCPC
R. Bond, MD, FRCPC
C. Chamberlain, MD, FRCPC
S. Holbrook, MD, FRCPC
S. Menard, MD, FRCPC

Patient Information

Last Name _____ First Name_____ Middle_____

Date of Birth (MM/DD/YYYY) _____ Gender _____Healthcare # _____

Home Address _____ City_____ Province_____ Postal Code_____

***Family Doctor (First & Last Name)_____ Clinic Location_____**

Secondary Patient's Information *(if applicable)*

Last Name _____ First Name_____ Middle_____

Date of Birth (MM/DD/YYYY) _____ Gender _____Healthcare # _

Parent/Guardian

Name_____ Relationship_____

Primary Contact Number_____ ☐ Home ☐ Cell ☐ Work

Secondary Contact Number_____ ☐ Home ☐ Cell ☐ Work

Name_____ Relationship_____

Primary Contact Number_____ ☐ Home ☐ Cell ☐ Work

Secondary Contact Number_____ ☐ Home ☐ Cell ☐ Work

Caregiver (if applicable) _____ *Contact Number*_____ ☐ Cell ☐ Work

Caseworker (if applicable) _____ *Contact Number*_____ ☐ Cell ☐ Work

How would you like to be reminded of your child's next appointment? Please check <u>ONE</u>

☐ Phone Call _____ ☐ Text Message _____ ☐ Email _____

Please note that this information is used for appointment notifications only and will not include Doctor's advise, urgent matters or sensitive information. Associate Clinic will not use your email for frivolous, commercial, or unapproved purposed.

CONSENT FOR ROUTINE RELEASE OF INFORMATION

To assist in the continuity of care for your child, often it is necessary to send clinical information to other health care providers. To provide for prompt transmission of this information **I (parent/guardian) consent to the release of any medical information on behalf of my child (patient noted above) my doctor deems necessary**. I understand the reasons for the disclosure of this information, and that I may revoke my consent at any time by providing a signed, written statement to that effect.

Parent/Guardian Name (Print)_____Signature_____ Date_____

May 2022