

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

*****You will receive a reminder text prior to upcoming in person appointments*****

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 _____