ASSOCIATE PEDIATRICS CLINIC
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PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

FIRST NAME: _____ LAST NAME: _____
(as written on health care card)

PREFERRED NAME: _____
(Also Known As ex: Elizabeth "Betty" or William "Bill" or prefers to be called by middle name)

ALBERTA HEALTH CARE #: _____

BIRTHDAY(MMM/DD/YYYY): _____PRONOUNS & GENDER: _____

MAILING ADDRESS: _____ CITY: _____

PROVINCE: _____POSTAL CODE: _____

FAMILY DOCTOR: _____

FAMILY DOCTORS' CLINIC NAME: _____

PREFERRED PHARMACY: _____

CONTACT INFORMATION

PARENT/GUARDIAN NAME 1: _____
- ○ HOME #: _____ ○ CELL #: _____
- ○ WORK #: _____ ○ WORK EXT #: _____
- ○ EMAIL: _____

PARENT/GUARDIAN NAME 2: _____
- ○ HOME #: _____ ○ CELL #: _____
- ○ WORK #: _____ ○ WORK EXT #: _____
- ○ EMAIL: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

CONTACT #: _____

CAREGIVER: _____ CONTACT #: _____
(If Applicable)

CASEWORKER: _____ CONTACT #: _____
(If Applicable)

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_____