

### New Patient Registration Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
DOB (MM/DD/YYYY): \_\_\_\_\_ Gender:  M  F  Other: \_\_\_\_\_  
PHN (Alberta Health Card #): \_\_\_\_\_  
Out of Province, Card# \_\_\_\_\_ Province \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ Mobile: \_\_\_\_\_  
Email: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Current Family Doctor: \_\_\_\_\_  
Would you like us to request your medical records?  Yes  No  
If yes, Please provide Previous Clinic Name and Fax: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_

#### Medical History:

Allergies: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Surgeries: \_\_\_\_\_  
Maternal: \_\_\_\_\_  
Paternal: \_\_\_\_\_

#### Life Style:

Exercise: \_\_\_\_\_ Smoke: \_\_\_\_\_ Tobacco: \_\_\_\_\_ Cannabis: \_\_\_\_\_ Alcohol: \_\_\_\_\_

#### Consent & Acknowledgment

- I consent to Belief Medical Clinic collecting and using my health information in accordance with the Health Information Act (HIA).
- I understand that email/text may not be fully secure and consent to be contacted for clinic communications.
- I agree to provide at least 24 hours' notice for appointment cancellations to avoid any late cancellation fees.
- I confirm all information above is accurate and complete.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Clinic Use Only:**  ID Verified  AHC Verified  EMR Record Created

Physician: \_\_\_\_\_ Staff Initials: \_\_\_\_\_