MONTEREY MEDICAL CLINIC

Unit 750, 2220 68th St. NE
Calgary, Alberta T1Y6Y7

Phone : 403.454.5140
Fax : 403.454.5719

PATIENT REGISTRATION FORM

Personal Details		*Address Details*	
Title (Circle)	Mr. Ms. Mrs.	Street Address:	
Surname:			
First Name:		City:	
Middle Name:		Province:	
Preferred:		Postal Code:	

Contact Details		*Emergency Contact Information*	
Home Tel No:		Emergency Contact:	
Work Tel No:		Telephone number:	
Mobile Tel No:		Relation:	
Email Address:		Patient's Gender	MALE / FEMALE

Alberta Health Care Number

Date of Birth	Day	Month	Year

Medical/Surgical History

Current Medication (Vitamins, Herbs & Over the counter meds)	
Medication	Dosage / Length of Use

Allergies to Medication	Reaction Description
Other Allergies	Reaction Description

SURGERY		
Date	**Procedure**	**Hospital**

Hospital Visits (Non – surgical)	
Date	**Reason for Visit**

Lifestyle / Family History

Smoker? ☐ **Yes** ☐ **No** **Years Smoking:**_____ **Cigarettes/day:** _____

Ex- Smoker?	**__Yes __No How many years have you quit smoking?**_____
Alcohol?	**__Yes __No**
Regular Exercise:	**__Yes __No Exercise Frequency:**
Family History:	**Heart Attack** ☐
Please indicate any other Medical conditions that are in your family history:	

Additional Information:

** Please be advised the registration information collected will be used for creating a patient file and billing purposes.

** The Clinic may need to contact you with regards to your appointment. From time to time, we may need to leave messages for you and ask that the contact information you provide to us may be used for this purpose.

Should you attend the Clinic for **any form completion, please **call to book** and **provide us a copy of the form** as our doctors may need to review them before you set an appointment. Please be informed that there may be a **charge** with the form completion and our clinic **only accepts cash.**

_____ _____

Patient / Guardian's Signature **Date**

**** All Questions contained in this questionnaire are strictly confidential and will become a part of your medical record ****