Ridgeview Medical Centre

NEW PATIENT FORM

Please print clearly.

PATIENT DETAILS					
Last Name					
First Name				**Middle Name**	
Date of Birth				☐	☐
	DD	**MMM**	**YYYY**	Male	Female

Health Care No.		**Province:**		**Expiry :**	

NOTE: Fees apply if a valid health care number is not provided at the time of your visit. Payment is to be made prior to seeing the doctor.

Permanent Mailing Address				
	Street / PO Box	**City/Town**	**Prov**	**Postal Code**

Must correspond with the address registered with your Health Care Card.

Local Mailing Address				
	Street / PO Box	**City/Town**	**Prov**	**Postal Code**

Contact Details			
	Home Phone	**Cell**	**Work**
	Email		

Emergency Contact		
	Name	
	Phone	**Relationship to Self (ie. Mother, Father, Brother etc.)**

It is RMC office policy to charge patients that fail to arrive for their booked appointments. Patients will be invoiced depending on appointment type. Subsequent appointments will not be booked until the account is settled. By signing below you acknowledge that you understand and agree to these terms. Cancellations with less than 24 hours notice or late arrivals may be considered missed appointments.

Signature:_____ **Date:** _____

Please return completed form to the front desk with proof of identity and your Provincial Health Care card.

Last Updated: June 2015