MediCross Clinic Patient Registration Form

Surname: _____

First Name: _____

Middle Name: _____ Nickname (i.e., Robert – Bob): _____

Date of Birth: _____ Alberta Health Care #: _____

Mailing Address: _____

_____ _____
(Postal Code) (Province)

Phone #: _____(C) _____(H)

Email: _____
(For email confirmations and AVA Connect)

Previous Family Physician: _____

Primary Pharmacy: _____

Medications: Obtain an updated official medication list printed from your pharmacy(s) and attach IF on any medications. Also, important to bring a list of vitamins, herbs, or minerals with dosages to first appointment.

Previous Medical Problems / Previous Surgeries OR NO MEDICAL PROBLEMS

(Personal Medical Problems) (Previous Surgeries)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Known allergies: _____

Occupation: _____

Please Circle

Marital Status: Single Married Separated Widowed Partnered Other

Do you exercise regularly? Yes No

Do you smoke? Yes No Quit (What year did you quit) _____ Vape

How often do you consume alcohol? Regular Intake Non-Daily Former/Quit Non-Drinker

Do you or have you ever used street drugs? Yes No Quit Type used: _____