MILLBOURNE MALL MEDICAL CENTRE

REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex: ❑ M ❑ F	Birth date : DD/ MM/YYYY
Health Care card #	Home Phone			Cell
Street address:	City:	Province::		Postal Code:

MEDICAL HISTORY

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Allergies ❑ Yes please list ❑ No

Medication ❑ Yes please list ❑ No

Surgeries: ❑ Yes please list ❑ No

Medical Conditions ❑ Yes please list ❑ No

FAMILY HISTORY

Colon Cancer	❑ Yes	❑ No
Heart Conditions	❑ Yes	❑ No
Breast Cancer	❑ Yes	❑ No
Prostate cancer	❑ Yes	❑ No
Hypertension	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Ovarian Cancer	❑ Yes	❑ No

REFERRING INFORMATION

How did you hear about us?

❑ Family ❑ Friend _____ ❑ Post card ❑ Radio ❑ Newspaper ❑ Other:_____

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

If you are unable to make it for your appointment, please call the office within 24 hour to cancel or reschedule your appt.
No show fee will be charged based on the type of the appointment.

Patient/Guardian signature *Date*