PATIENT INFORMATION SHEET

NAME: ____

STREET ADDRESS: ____

TOWN: ____ POSTAL CODE: ______________________

HOME PHONE: ____________________________ WORK PHONE: ______________________________

CELL PHONE: ___________________________EMAIL: ____

PHYSICIAN: _________________________________PHYSICIAN'S PHONE #: ______________________

BIRTHDAY (Y/M/D): ____

HEALTH CARD #: _____________________________

BLUE CROSS # (ONLY IF MILLITARY, RCMP, VETERAN'S AFFAIR PERSONEL)

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