**PATIENT REGISTRATION**

Please complete this registration form to ensure that your Electronic Medical Record contains complete and up to date information. This information is confidential. Please print this form, complete it and **fax it to (705) 792-4009 or email to: doctorkwright@gmail.com.**

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| --- | --- | --- | --- | --- |
| **Name**  Last | | First: | | |
| Preferred Name: | | Maiden/Previous: | | |
| Date of Birth:  Day month Year | | Male Female Other | | |
| Health Card Number: | | | Version Code: | |
| Address: | | | | City: |
| Postal Code: | | | | |
| Main Contact Number: | Alternate Phone Number: | | | |
| Work Phone Number: | | | | |
| Email address:  (to be used by the Clinic in Medeo® to send test results, notes and other documentation) | | | | |
| Emergency Contact Information  Name: | Cell Phone Number: | | | |
| Relationship to you: | Is this person also a patient here? | | | |
| Children (living at home and patient(s) here)  Name:  Name:  Name: | Date of Birth:  Date of Birth:  Date of Birth: | | | |
| Pharmacy Preference: | | | | |
| Attorney for Care (POA)  Name: | Contact Number:  Relationship to you: | | | |