KINGSRIDGE MEDICAL CLINIC

PATIENT REGISTRATION FORM

Unit 101- 225 Carleton Drive
St. Albert, AB T8N 4J9
Phone: 780-569-5455 **Fax:** 780-569-5145

PLEASE PRINT CLEARLY

First Name: ________________________________

Last Name: ________________________________

Middle Name: _____________________________ **Gender:** M / F

Birth Date: **Day**: ________ **Month**: ________ **Year**: _________ **Age**: ________

Alberta Health Care Number: ____________________

Other Alberta Health Care (if not Alberta): __________________ **Province**: ___________

Mailing Address: ____

City: _______________ **Province**: _________________ **Postal Code**: _______________

Home Phone: ________________ **Cell Phone**: _____________ **Work**: __________________

Email Address: ____

Person to contact in case of emergency: Name: ____________________________

Phone number: ______________________

Relationship: ________________________

Any Allergies to medications, foods, LATEX, etc:__________________________________

NO SHOW POLICY: $40 FEE FOR MISSED APPOINTMENTS/ LATE CANCELLATION
$ 50 FEE FOR MISSED PHYSICALS/SPECIALIST APPOINTMENTS
WE REQUIRE 24 HRS NOTICE OF CANCELLATION.

Patient Signature: _____________________________ **Date**: ______________________