Patient Registration

Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ Maiden/Previous: _____

Date of Birth: _____ / _____ / _____ ☐**F** ☐**M** **Personal Health No:** _____
Day Month Year

Address: _____

City: _____ Prov: _____ Postal Code: _____

Contact Info: Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer's Name: _____

Other Phone: _____ (Who/Relation?): _____

Preferred Phone: ☐Home ☐Cell ☐Work ☐Other

E-mail: _____ (To be used by Gateway Health & Wellness Centre to send patient information resources and communicate appointment reminders and other notifications.)

Spouse (if applicable) **Tick if spouse is or will be a patient here** ☐

Name: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____

Children (living at home): **Enter ONLY if child is or will be a patient here**

Name: _____ Date of Birth: _____ PHN: _____

Name: _____ Date of Birth: _____ PHN: _____

Name: _____ Date of Birth: _____ PHN: _____

Name: _____ Date of Birth: _____ PHN: _____

Parents (if patient is under 20yrs old)**:** _____ Phone: _____
Tick if parent NOT a patient here ☐

List any above family members requiring a doctor: _____

Lead Care Giver (if other than parent)**:** _____ Phone: _____

Second Contact Person/Next of Kin (other than spouse)

First and Last name: _____ Phone: _____

Relationship to Next of Kin: _____