reliance
MEDICAL CLINIC
LANGLEY

NEW PATIENT REGISTRATION FORM

First Name:	
Preferred Name:	
Address:	
City:	
Postal Code:	
Province:	

Last Name:	
Date of Birth:	
Care Card/PHN:	
Gender:	
Tel. Number:	
Mobile Number:	
Email Address:	

EMERGENCY CONTACT INFORMATION

First Name:	
Relationship:	

Last Name:	
Tel. Number:	

MEDICAL AND SURGICAL HISTORY

Past Medical History:

Past Surgeries and Procedures *(include dates)*:

Family History

(Please indicate any significant medical issues among family members and who they affect)

Prescription Medication:

Non-Prescription Medications:

Allergies:

Allergic Reaction:

When did you last have the following:

PAP Smear:	
Mammogram:	
Bowel Screening Test:	

Flu Shot:	
Tetanus Shot:	
Colonoscopy:	