

MediCross Clinic – New Patient Registration Form

Surname: _____

First Name: _____

Middle Name: _____ Nickname (i.e., Robert – Bob): _____

Date of Birth: _____ Alberta Health Care #: _____

Mailing Address: _____

(Postal Code)

(Province)

Phone #: _____ (C) _____ (H)

Email: _____

(For email confirmations and AVA Connect)

Previous Family Physician: _____

Primary Pharmacy: _____

Emergency Contact: Name _____

Phone # _____ Relationship _____

Medications: Obtain an updated official medication list printed from your pharmacy(s) and attach IF on any medications. Also, important to bring a list of vitamins, herbs, or minerals with dosages to first appointment.

(Personal Medical Problems)

(Previous Surgeries)

Known allergies: _____

Occupation: _____

Please Circle

Marital Status: Single Married Separated Widowed Partnered Other

Do you exercise? No Yes (how often): < 60 min/wk < 90 min/wk < 150 min/wk 150+ min/wk

Do you smoke? No Yes (how many per day) _____ Quit (what year) _____ Vape

Do you consume alcohol? No Former/Quit (what year) _____

Yes (how often): < 1/wk < 5/wk < 10/wk 10+/wk

Do you or have you ever used street drugs? No Yes Type used: _____ Quit