Banff Sport Medicine

Patient Registration

Health Care	Number	Province	Expiry Date (if applicable)	**Today's Date**	
Name	***As it appears on your Health Care Card***				
	Full Name - *if **different** than name on Health Care Card*				
Date of Birth	Day / Month / Year			**Age**	**Sex**
Address	Street/Mailing				
	City/Town	Province	Postal Code		

Email	Primary Email	☐ Personal ☐ Work ☐ Other	Secondary Email	☐ Personal ☐ Work ☐ Other
Contact Number	Primary Phone Number	☐ Cell ☐ Home ☐ Work ☐ Other	Secondary Phone number	☐ Cell ☐ Home ☐ Work ☐ Other
Occupation	Job Title	Employer	Phone Number	

Family Doctor	Name	Clinic Name/Location	Phone Number
Emergency Contact	Name	Relationship	Phone Number

Is this a work-related injury?	☐ **NO,** *if no skip section.* ☐ **YES,** *if yes please answer the following questions.*

Date of Injury:	Location:
Employer at time of injury:	
Nature of injury:	
Social Insurance Number:	WCB Claim Number:

Banff Sport Medicine Uninsured Services Policy: Fees for uninsured services (not covered under provincial health care plans) will be at the discretion of the physician. This includes but is not limited to forms required by third parties and government agencies.

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