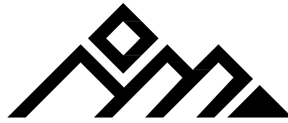

Banff Sport Medicine

PATIENT REGISTRATION

Please print Date ____________________

Patient Legal Name ____
Last Name First Name Middle Name or Initial

Address ____
Street P.O. Box

City, Province ____

Postal Code ____________________ E-mail Address ____________________

Phone: Residence ______________ Cell ______________ Business ______________ ext. ______

Birthdate DAY ______ | MONTH ______ | YEAR ______ Age ______ Sex ______

Health Care Number ____________________ Province ____________________

Referring Doctor/Clinic Name/Phone Number ____________________

Family Doctor/Clinic Name/Phone Number: Same ❑ or ____________________

Nearest Relative/Spouse ____
Name Relationship

____
Address Telephone

Patient's Occupation ____________________ Employer ____________________

IF APPLICABLE:

Is this a work related injury? Yes ❑ No ❑ Date of injury ____________________

Location ____________________

Employer at time of injury ____________________

Nature of injury ____________________

Social Insurance Number ____________________ WCB Claim Number ____________________

Please note: Employment Insurance (EI) forms are subject to a minimum $15 fee and private insurance forms are subject to a minimum $50 fee for EACH form completed by the attendant physician.

Updated January 2016