West Kelowna Medical Clinic

Unit 105, 2231 Louie Drive
West Kelowna, B.C. V4T 3K3

Tel: 250-768-6985
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Email: westkelownamedical@shawbiz.ca

NEW PATIENT INFORMATION & REGISTRATION FORM

DATE:_____

Health Care # _____ Is this a BC Health Care Number? Yes / No Province: _____

Name (as it appears on your medical card)

Last Name:_____ First Name:_____

Middle name: _____ Preferred Name: _____ Mr./ Mrs . / Miss / Ms.

Birth Date: Day _____ Month _____ Year _____ Sex: M or F

EMERGENCY CONTACT PERSON _____Relationship to Patient?_____

Phone Number of Emergency contact Person _____

Complete Mailing Address:

Unit/Suite/Apt: _____ Street No: _____ Street Name: _____

City: _____ Province:_____ Postal Code: _____

Home Phone: _____ Cell or Alternative phone: _____

Email Address: _____

May we contact you by email regarding test results/appointments? Yes / No

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Medical Information:

Do you have a Family Doctor? Yes/ No

Family Doctor: _____ Location: _____

Allergies: _____

Current Medications: _____

Preferred Pharmacy name and location? _____

Current Health Issue/s: (Circle all those that apply or leave blank if none apply.)

Diabetes Heart Attack Angina High Blood Pressure Cholesterol Epilepsy

Thyroid Lung Disease Ab pain migraine/headaches Fibromyalgia Asthma

Chronic Back pain acne Cancer Depression/anxiety Stroke