

# Patient Information Form

**Date of Birth:** month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

**Last name:** \_\_\_\_\_

**First name:** \_\_\_\_\_

**Citizenship:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home phone:** \_\_\_\_\_

**Work phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Employed by Company/Organization:** \_\_\_\_\_

**Method of payment:** \_\_\_\_\_

(cash, credit card, insurance, OHIP, cheque, money transfer, PayPal)

**Known allergies:** \_\_\_\_\_

## Contact in case of emergency

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Home phone:** \_\_\_\_\_ **Work phone:** \_\_\_\_\_