NEW PATIENT FORM

PHYSICIAN REQUESTED (Please Circle) Dr. Pitre / Dr. Takacs / Dr. Tahira /No Preference

Last Name _____ First Name _____

Date of Birth _____ Gender _____

Address _____

City _____ Postal Code _____

Email _____

Health Card Number _____ VC _____

Home _____ Mobile _____ Work _____

Current Family Doctor _____

Medical Problems _____

_____

Medication Allergies _____

Medications (include doses and how often taken, or attach list from pharmacy):

_____ _____

_____ _____

_____ _____

_____ _____