CLEAR

Fortress Medical Clinic – Patient Registration Form

PATIENT DEMOGRAPHICS

Last Name:	
First Name:	
Middle Name:	
Birthdate (mm-dd-yyyy):	
Health Card No:	
Sex:	
Marital Status:	☐ Single ☐ Married
☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr.	

CONTACT INFORMATION

Street Address:	
City:	
Province:	
Postal Code:	
Home Phone No:	
Alternate Phone No:	
Email Address:	

PREVIOUS FAMILY PHYSICIAN

Name:	
Phone No:	

EMERGENCY CONTACT

Name:	
Relationship to Patient:	
Contact Phone No:	

PERMISSIONS

Do you give permission for Fortress Medical Clinic to leave you detailed voicemails in the event we are unable to reach you for clinic correspondence? ☐ Yes ☐ No
Do you give permission for Fortress Medical Clinic to correspond with family or friends on your behalf? ☐ Yes ☐ No
May we add you to our email list for updates, schedule changes, and important news? ☐ Yes ☐ No

Medical Conditions/Past Medical History

Please list current and past medical/mental health conditions and any surgeries you have undergone. Please include the name of your specialist if applicable. Feel free to attach another page if more space is required.

Condition	Specialist

Family History

Are there any medical/mental health conditions that run in your immediate family? Please list family members of condition if known.

Family Member	Condition

Medications

Please list all medication (prescribed, over the counter, supplements/vitamins). Please list the reason you are taking these medications. Please feel free to attach another page if more space is required.

Medication	Reason (if known)

Allergies

If you have any allergies, please list it below and include the reaction.

Allergies	Reaction

Social History

Do you?

Smoke	☐ Yes ☐ No
Use Alcohol	☐ Yes ☐ No
Use Recreational Drugs	☐ Yes ☐ No

Thank you for completing this form. Your information will be treated as confidential. Please feel free to include any information or comments below.

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