Bonafide Medical Clinic

Patient Information

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____/_____/_____ Sex: M F

Health Card #: _____ Version Code: _____

Expiry (MM/DD/YYYY): _____/_____/_____

Street Address: _____

City: _____ Postal Code: _____

Best Contact Number: _____

Email Address: _____

Emergency Contact Name / Relation: _____ / _____

Emergency Contact Number: _____

Medical History

Medical Conditions: _____

Allergies: _____

Family Doctor: _____

Reason for your visit: _____

How did you hear about us? _____

_____ _____

Patient Signature Date