NuCARE Medical

4302 17th Ave SE
CALGARY, AB, T2A0T4
P: 587-779-8887 F: 587-747-0180

REGISTRATION FORM

Thank you for choosing our clinic! To help serve you better please fill out this form. All information provided will remain confidential.

PATIENT INFORMATION

Last Name	*First*	*Middle*	*Title*
			☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs.

Is this your legal name	*If not what is your legal name*	*Preferred name*
☐ Yes ☐ No		

Marital status	*Sex*	*Birth Date (dd/mm/yyyy)*	*Age*
☐ Single ☐ Div ☐ Sep ☐ Common Law ☐ Married ☐ Wid	☐ M ☐ F	/ /	

Street Address	*City*	*Province*	*Postal Code*

Email address (appt. reminders)	*Occupation*	*Home Phone Number*	*Cell phone Number*

Spouse/ Parent/ Guardian Name	*Health Care Number (Required)*	*Is this an Alberta HCN?*
		☐ Yes ☐ No

How Did You Hear About Us	*Emergency Contact Name*	*Emergency Contact Number (C/W/H)*
☐ Radio ☐ Internet ☐ Friend /Relative ☐ Doctor Referral ☐ Other:_____	*Relation:*	

DISCLAIMER

I, the Patient/ Patients legal representative, hereby grant permission to the Oasis Medical Clinic and its authorized representatives to perform examinations/treatment deemed necessary or advisable for my/patient's diagnosis and treatment. I have voluntarily provided the above information to the best of my ability and authorize Oasis Medical Clinic to contact and use any of the given information. The information provided will not be shared with a third party unless an agreement is signed by the patient. I understand that I am responsible for any fees that are not covered by Alberta Health or my insurance company (If applicable). This Clinic/Clinic's representatives do not warrant the completeness, timeliness or accuracy of any of the treatment or services provided.

The Oasis Medical Clinic and/or its physicians shall not be liable for any damages, claims, liabilities, costs or obligations arising from the service or non-service provided.

Signature	*I agree to the above*	*Date*
	☐ Yes ☐ No	