Patient Registration Form

Patient Name: ____

Street address: ____

City / Town: ____

Province: ____

Postal Code: ____

Phone numbers: ____

Email address: ____

Date of Birth: (day / month / year)____________________________

Family Physician's name: ____

Have you seen a physician regarding your injury or current condition? physician. Yes / No If 'yes', please indicate where saw a physician.

Please list all medications you are currently taking (use reverse side of this sheet if needed)

Have you undergone diagnostic imaging such as x-rays for your injury or current condition? Yes / No

Are you currently being treated by another healthcare professional for the same complaint you are seeing Terry Kane for. Yes / No. If yes, please list other healthcare professionals by name:

I am aware that Terry Kane does not treat patients with injuries resulting from work related accidents, motor vehicle accidents or patients involved in medical-legal litigation AND that a failure to disclose this, in writing, will result in the immediate termination of care and withholding of all patient records, requested by myself (patient name) or any agent acting on my behalf in the future.

Signature: ____**Date**: _________________________