



REGAL HEALTH SERVICES

123 Edward St. Suite 1106, Toronto ON M5G 1E2

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info@regalhealthservices.com

PATIENT INFORMATION

PLEASE NOTIFY OUR OFFICE OF ANY CHANGES

NAME: _____ D.O.B. _____
(Please Print) Day Mo Year

ADDRESS: _____
Street/R.R.# Apartment or Unit

City/Town/Province Postal Code

OHIP NUMBER: _____ Version Code ()
Expiry date on green OHIP card _____ (Letter(s) After Number)

CONTACT NUMBERS

Home Phone: _____ Fax: _____

Business Phone: _____ Mobile Phone: _____

May we leave confidential messages on your voicemail? Circle

Home Y N Work Y N Cell Y N

E-mail Address: _____@_____.

OK to email you information such as appointments etc? Y N

Pharmacy Name & Address: _____

Pharmacy Number(s): _____ FAX _____

Known Allergies: _____

(Seasonal & Drug Related)

Last Physical: _____ Physician: _____

(Approximate Date) Address: _____

Signed _____ Date: _____