



Registration Form

CONFIDENTIAL INFORMATION

Last Name		First Name		Middle Name		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is your legal name?		Birth Date MM DD YYYY / /		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address			City		Postal Code		
Home Phone Number ()		Work Phone Number ()		Cell Phone Number ()		Preferred contact # Home / Work / Cell (please circle)	
Your Email Address				Would you like to receive information via email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupation				Employer			
Name of Family Physician				Phone Number ()			
MSP Care Card Number		Do you have extended health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Insurance Company			

How did you hear about our clinic?

- Referred by
 Using services provided by other Electra Health Floor practitioners. Please specify
 Family/Friend Close to home/work Others. Please specify

IN CASE OF EMERGENCY

Name of Emergency Contact		Relationship	
Phone Number (Home/Work/Cell) ()		Phone Number (Home/Work/Cell) ()	

The above information is true to the best of my knowledge. I authorize the use of this information for my registration with Radiant Natural Health Clinic. I also authorize Radiant Natural Health Clinic and/or my insurance company to release my information required to process my insurance claim.

Patient/Guardian Signature

Date

Dr. Carol Y. Lin
Naturopathic Physician

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Optimize your health the natural way