Harbourside Medical Clinic

Box 250 Quathiaski Cove B.C. V0P 1N0
Ph: 250.285.2265 Fax: 250.285.2264
Email: office@hrbmc.ca

Patient Information Form

Last Name ____________________ First Name(s) ____________________

Preferred First Name ____________________ Date of Birth (Year/Mo/Dy) ____________________

Mailing Address ____

Street Address ____

Primary Phone Number____________________ Alternate Phone Number____________________

BC Health Card Number # ____________________; Location if Not BC ____________________

Sex: Male __________ Female __________ or Identify as: ____________________

Email ____

Preferred Pharmacy ____

Emergency Contact:

Name ____________________ Phone #____________________ Relationship____________________

Do you have any family members that are currently patients in our clinic? ____________________

Previous Family Physician (name & location): ____

____