# VIAMEDICA NEW PATIENT REGISTRATION FORM

| PERSONAL CONTACT INFORMATION | | | |
|---|---|---|---|
| Last Name at birth: | First Name: | | |
| Date of Birth: dd/mm/yy | Age: | Gender: M ale Female | |
| Address: | City: | Province: | |
| Postal Code: | Medicare Number: | | |
| Home: ( ) | Work : ( ) | Cell: ( ) | |
| Email: | Emergency Contact Name: | | |
| Emergency Contact Number: ( ) | Relation to patient: | | |

**CONSENT TO TESTING**

I hereby voluntarily consent to have testing and examinations performed at ViaMedica Medical Centre/Imaging Services as requested by my physician. I understand that this consent form will be valid and will remain in effect as long as I receive services at ViaMedica. This form has been explained to me and I fully understand this consent and agree to its contents.

**PATIENT ADVISEMENT OF THE PURPOSE OF COLLECTION OF HEALTH INFORMATION**

Please be advised that the registration information collected will be used for creating a patient file and for billing purposes. It will also be used for sharing of patient information to the ordering physician and any other physician designated by you. Please be advised that the clinic may need to contact you with regards to your appointment. From time to time, we may need to leave messages for you and ask that the phone numbers and email you provide to us may be used for this purpose.

**THIS SECTION APPLIES TO WORKERS' COMPENSATION EXAMS ONLY**

Is this exam being paid for by: ☐ **CSST** ☐ **SAAQ** ☐ **WSIB Ontario** ☐ **Other:**_____

By signing below you authorize ViaMedica to release your medical information to the workers' compensation insurance for the purpose of filing the insurance claim.

Your signature below indicates you understand and comply with the above statements.

*If under age 14 must be signed by parent or guardian.*

| **How did you hear about our clinic?** | |
|---|---|
| Signature: | Date: |
| Signature of Witness: | |

**ALLERGIES:** ☐ **None** _____ **Are you at risk of falling?** ☐ **Yes** ☐ **No**

**Français au verso / French on reverse**

3943 boul. St-Jean, Dollard-des-Ormeaux, Québec, H9G 1X2
Tél. 514-626-5888 • www.viamedica.ca • Fax 514-626-1228