WELL Health | GYNECOLOGY CENTRES

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WELLHEALTH GYNECOLOGY

PATIENT INFORMATION FORM

(please bring with you or fax to our office)

NAME on CARE CARD :_____
(Last Name, First Name)

Preferred First Name:_____

Gender Pronouns:_____

CARE CARD NUMBER:_____

ADDRESS :_____

City:_____ Postal code:_____

Email Address:_____.
PHONE NUMBER: _____. Alternate contact:_____

Preferred pharmacy (with fax number):_____

Medications currently on (with dose):_____

Allergies to medications:_____

Please tell us in your own words why you are being referred to our office: