CAPREOL NURSE PRACTITIONER-LED CLINIC

49 Young Street
Capreol, ON P0M 1H0
Telephone: 705-858-8787 / Fax: 705-589-3018

REGISTRATION FORM

Information (Please Print)		
Last Name:		
Given Names:		
Preferred Name:	Pronouns:	
Birth Date: (yyyy,mm,dd)		
Health Card #:		
Phone Number: home	work	cell
Address: Street Number	Street	Apt (if applicable)
City	Ontario, Canada	Postal Code
Email address:		
By providing your email address you consent to having emails sent to you by Capreol NPLC		
Gender Assigned at Birth:	Gender Identity:	
Ethnic/Racial Identity:		
Language (preferred):		
Please complete below for all clients with a legal guardian and for all children less than 16 years of age:		
Primary Guardian:		
Relationship:		
Phone Number: home	work	cell
Address: Street Number	Street	Apt (if applicable)
City	Ontario, Canada	Postal Code
Please describe where you have been receiving health care over the last two years:		
In general, how would you describe your health:		
☐ excellent	☐ good	☐ poor
☐ very good	☐ fair	
Allergies:		

REGISTRATION FORM (continued)

List Health Conditions and/or Health Concerns(please include a date your health concern started if know):
Please list any surgical procedures you have had in the past:

Medication (name, strength, frequency)	Reason for Taking Medication
e.g. Tylenol 500mg 3x/day	For arthritis pain

Providing false information may result in discontinuing the nurse practitioner-client relationship.
Please verify all information on this form is correct by providing your signature below.

Signature:	Date:

Upon completion of forms for more than one family member, please submit together.