PORT AUGUSTA
FAMILY PRACTICE

Unit 5 & 6-215 Port Augusta Street, Comox, BC V9M 3M9 **Phone#:** 250-941-1194 **Fax#:** 250-941-1193 **Website:** www.portaugustaclinic.com

New Patient Request

Date: _____

Personal Information:

Full Name (according to care card): _____ Sex: _____
First Name Middle Name Last Name M/F

Preferred Name (if different than on your Personal Health Card): _____

DOB: Month: _____ Day: _____ Year: _____

Personal Health Number: _____ Province: _____

Address (please include postal code):

_____

_____

_____

_____

Phone #: _____ Cell #: _____ Email: _____

Emergency Contacts:

Name: _____ Relationship: _____ Contact #:_____

Name: _____ Relationship: _____ Contact #:_____

Return to:
In person: Port August Family Practice, Unit 5 & 6 215 Port Augusta Street, Comox, BC V9M 3M9
Fax: 250-941-1193
Email: registercipa@gmail.com