



HENRY MEDICAL CENTRE

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reception@henrymedicalcentre.com

NEW PATIENT INTAKE FORM

Last Name: -----First Name: -----

Date of Birth: -----

Health Card #: -----

Current Family Doctor (If any): -----

Gender: -----

Phone #: -----

Email: -----

Address: -----

Diseases (If any): -----

Medication (If any): -----

☐ Pharmacy: Henry St. Remedy's Pharmacy

www.henrymedicalcentre.com

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