

**Saddle Mountain
Medical Clinic**

New to area ☐ or One time patient ☐

Patient's Full Name: _____
surname
first
middle name

Date of Birth: _____ / _____ / _____ Sex: M / F
Day Month Year

Name of Spouse/Parent/Guardian: _____

Mailing Address: _____

Email Address: _____

City: _____ Province: _____ Postal Code _____

Telephone Number: Home: _____ Cell _____

Employer: _____ Work/Alternate Phone: _____

Personal Health Care Number: (Care Card)

Previous Family Doctor _____ Telephone Number _____

Next of Kin (person to be called in case of emergency): _____

Phone Number _____

Patient's Maiden Name (if applicable):_____

If you are visiting in the Nakusp area can we contact you at an alternate address/telephone number?

Help us keep the air we share healthy and fragrance free!

Signature: _____

Parent/Guardian _____

Signature _____
(if under 16)

Office Use Only:

Entered By: _____ (initials)

SMMC Physician: _____

Set status - Office pt or ER if walk in.

Confirm PHN

SCENT

FREE

ZONE