Klinic COMMUNITY HEALTH

DATE RECEIVED (FILL BY FRONT DESK): _____

# TRANS HEALTH REGISTRATION FORM

*Please complete all sections and return to Klinic front desk or by mail (address on p. 3)*

**Personal Information**

Chosen Name (First Name, Last Name): _____ Date of Birth: _____

Legal Name (Name on Health Card): _____ (Please Include Middle Name)

Please let us know what name we should use when:

| | Chosen Name | Legal Name | Use This Specific Name: |
|---|---|---|---|
| We Phone | ☐ | ☐ | |
| Send Letters / Mail | ☐ | ☐ | |
| In the Waiting Room | ☐ | ☐ | |

Pronouns: _____ Gender Identity: _____

**Health card numbers:**

Manitoba Health PHIN (9-digit): _ _ _ _ _ _ _ _ _ MFRN (6-digit): _ _ _ _ _ _

Other province: _____ Health Card Number: _____

**Contact Information:**

Mailing Address, City, Postal Code: _____

Physical Address (if different from above) _____ City_____

Phone Number #1: _____ Please Circle Type: Home Cell Work

Can we leave you a voicemail: ☐ Yes ☐ No

Phone Number #2: _____ Please Circle Type: Home Cell Work

Can we leave you a voicemail: ☐ Yes ☐ No