



Registration Form

Date: _____

Name and Address – We ask for your name, date of birth, and gender currently registered with Manitoba Health to ensure any medical tests done by us will match your health record. However if you would like to self-identify your gender in a different way, we want to know that too, so we can provide the best possible care to you. If any of this information changes in the future – please let us know immediately so we can make the correction in our records.

Legal Name: (as listed on your **Manitoba Health Card**) _____
(First Name) (Last Name)

What name do you go by? _____ Pronouns: _____

PHIN #: (9-digit #) _____

Manitoba Health #: (6-digit #) _____

Date of Birth: Month _____ Day _____ Year _____

Gender:
 male
 female
 nonbinary

Current Address: _____
(#) (Street Name) (City) (Province) (Postal Code)

Can we send you mail to this address if we can't reach you by phone? Yes No

Other address/special instructions for mail? _____

We ask the best way to contact you by phone in case we need to reach you with important information. If we can't reach you we will leave a message to call us back. We will not leave personal health information on a voice mail without your express consent. Please do not list any phone numbers that you do not want Klinik to call:

DO NOT list Phone Number(s) that you do not want Klinik to call:

Home phone: _____	<i>Preferred number to call (pick one):</i> <input type="checkbox"/> Home	<i>Can we leave a Klinik message?</i> <input type="checkbox"/> Home
Work phone: _____	<input type="checkbox"/> Work	<input type="checkbox"/> Work
Cell phone: _____	<input type="checkbox"/> Cell	<input type="checkbox"/> Cell
Other: _____	<input type="checkbox"/> Other	<input type="checkbox"/> Other

Alternate Contact Person:
(in case we are unable to contact you at the above numbers or in the case of an emergency while you are here at Klinik)

DO NOT fill in this box if Klinik cannot leave a message with this person.

Name: _____ Relationship to you: _____

Phone number: _____

Do you require an interpreter? No Yes If yes, what language? _____

IMPORTANT: Please let us know if any of this information has changed so that we can update your health record immediately. *Thank you.*

DRAFT