Glen Sather University of Alberta Sports Medicine Clinic
Kaye Edmonton Clinic, Level 2
11400 University Avenue
Edmonton, AB T6G 1Z1

PATIENT REGISTRATION FORM

Personal Contact Information

Name: _____ **PHN**: ___ ___ ___ ___ ___ - ___ ___ ___ ___ **(_____)**
Surname Given Name Middle Personal Healthcare Number Province

Address: _____**City**: _____**Prov**: _____

Postal Code _____Phone: home( ) _____ Work( ) _____ Other() _____

Date of Birth: _____ /_____ /_____ **Age:** _____ **Gender:** M F
Year Mon Day

Email Reminder Consent

I understand the risks/benefits of email transmission and request that future appointment reminders be sent

electronically to the following email address: _____

_____Yes, please send appointment reminders via email ____ No, please don't sent appointment reminders via email
Please Initial here for YES Please Initial here for NO

Employment Information

Occupation: _____**Employer:**_____

Employer's Address: _____**City**:_____

Emergency Contact Information

Emergency Contact _____**Phone**:( )_____- _____
Name Relation

Family Physician: _____**Phone**:( )_____- _____

Patient Advisement of Purpose of Collection of Health Information

Please be advised the registration information collected will be used for creating a patient file and billing purposes. The information is being collected under the authority of sections 20(b) and 21(1) the *Health Information Act*. The provisions of the *Health Information Act* protect your privacy and the confidentiality of your health information. The *Health Information Act* provides for sharing of patient information between healthcare providers when said sharing contributes to the continuing care and treatment of the patient.

Please be advised the Clinic may need to contact you with regards to your appointment. From time to time, we may need to leave messages for you and ask that the contact information you provide to us may be used for this purpose.

Should you attend the Clinic for assessment and treatment related to a work related injury, the Clinic, under contract with the Worker's Compensation Board (WCB), must report your injury to the WCB, and will share your medical information with the WCB as it pertains to the injury in question. Should your claim be denied by the Worker's Compensation Board, you will be responsible for paying all physiotherapy assessment and treatment costs through the Glen Sather Sports Medicine Clinic.

If you have any questions about the collection and use of your personal/health information, please contact the Glen Sather Sport Medicine Clinic at 407-5160. Your signature below indicates you understand and comply with the above statements.

Missed appointments and short notice cancellations result in inefficient use of healthcare provider resources. In an effort to decrease the incidence of these occurrences a $50.00 fee for any <u>missed</u> appointments and those appointments <u>cancelled</u> without 24 hours notice will be levied.

Patient Signature: _____Print Name: _____ Date: _____ /_____ /_____
If under 18 years of age, must be signed by parent/guardian Year Mon Day