Patient Registration Form

Please note that the personal information provided on this Registration Form must match the information that appears on the Medical Document or Registration Certificate.

PATIENT INFORMATION:

First Name	Last Name	Gender (M,F, Other)	Date of Birth (YYYY/MM/DD)

Email	Phone Number	Fax Number (optional)	Is this a registration or renewal?
			Registration Renewal

If you are renewing, what is your Patient ID #?	Veteran's Affairs Number (if applicable)	Tax Exemption Code (if Applicable)

SHIPPING AND MAILING INFORMATION:

Please provide the primary residence of the Applicant. Primary residence must be within Canada.

Preferred Language:
English French

Primary Address:

Address Line 1	Address Line 2

City	Province	Postal Code	Country

Shipping Address:

Address Line 1	Address Line 2

City	Province	Postal Code	Country

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