PrimeCare+

PATIENT REGISTRATION FORM

Please complete this form and mail it back
Dates of coverage: November 1 to November 1, 2018.

1. Name(s)

ATTENDING DOCTOR (Select patient's doctor - one only)

	Dr.Wu	Dr. Van Raay
1 _____	¤	¤
2 _____	¤	¤
3 _____	¤	¤
4 _____	¤	¤

2. Address: _____

3. Home phone: _____ **Cellular:** _____

4. Email Address: (1) _____ **(2)** _____

5. Select the coverage plan of your choice:

__ **Individual $145** __ **Family $240** (**Families** are defined as **two parents** and all **dependent** children under 18 years old)

6. Choose one of the following payment options:

a. Credit Card Please check one: Visa ¤ MasterCard ¤

Name on card: _____

Card Number: _____ Expiry (Month/Year): _____/_____

Security code (CVV code) on the back of the card: __ __ __

b. Mail this form back with a cheque made out to:

PRIMECARE MEDICAL CLINIC
508 15 Ave SW, Calgary, AB T2R 0R2

(This is your income tax receipt once signed and stamped)

For Office Use Only