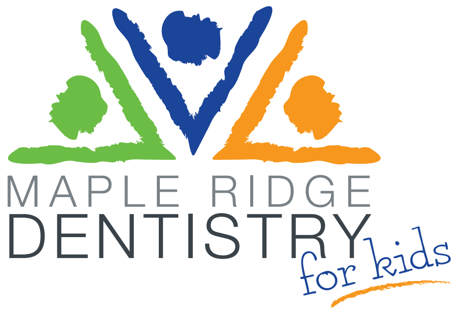


Date: ___________________________

Name: ___________________________ Birthdate: ___________________________

B.C. Care Card Number: ___________________________

Guardian: ___________________________ Relationship: ___________________________

Address: ___________________________

Home Phone: ___________________________ Cell Phone: ___________________________

E-mail Address: ___________________________

Insurance: ___________________________

Policy Holder: ___________________________

Birth Date (dd/mm/yyyy): ___________________________

Medical Concerns: ___________________________

____

Reason for Referral: ___________________________

____

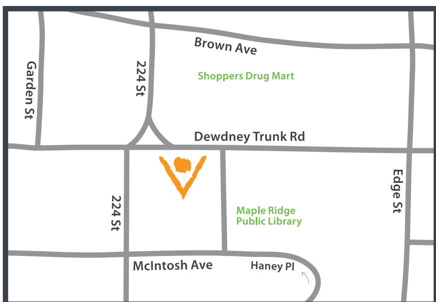
____

X-rays sent by Mail E-Mail Not Available

Referred by: ___________________________ Phone: ___________________________

Refer patient back after completion of treatment No Yes

Your visit is booked for ___________________________



Fees are as per the specialist fee guide.

Dr. Nancy Vertel, Certified Specialist -
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