Silverado Medical Clinic

#806, 19369 Sheriff King Street SW Calgary, AB T2X 0T9

Tel: (403) 873-7300 Fax: (403) 873-8880

Pediatric Intake Form

Child's full name (first, middle, last):_____

Date of Birth: _____ Health Care #:_____

Address:_____

_____

Parent/Guardian's Name: _____ Relationship to the child _____

Home Phone: _____ Cell/alternate: _____

Email: _____

CLINIC INFORMATION

Medical Condition(s)	Specialist Name	Current Medication(s) and dosage:

Intolerance /Allergies (please describe reaction) : _____ ( ) NONE

_____

_____

History of surgery and or hospitalizations? ( ) NO ( ) YES

List of surgeries and/or hospitalizations and date(MM/YY):

The above information is true to the best of my knowledge.

Parent/Guardin Signature:_____ Date (dd/mm/yy):_____