MAYFAIR
EYE CARE

New Patient Admission Form

Name: Mr/Mrs/Ms/Miss: _____
Address:_____
Phone Number (Home):_____(Work):_____ (Cell):_____
Email Address:_____
Family Doctor (Name):_____ (Address):_____
(Phone Number):_____
Alberta Health Care Insurance Plan (AHCIP) #:_____
Insurance Company Name and Number:_____
Do you have coverage by a government funded program? If so, which one?
_____
Occupation:_____
How did you hear about us? (Please circle): Family/Friend/Co-Worker/Website/Other (If other please specify)_____