



**PHARMACIE**  
**PIERRE-MARC GERVAIS**

3421, avenue du Parc, Montréal QC H2X 2H6  
Tél. : 514 788-3656 • Fax : 514 788-3657

## REGISTRATION FORM

Save time and help us serve you better! Fill out the form below and bring it to the pharmacy for quick and easy processing of your prescription.

### GENERAL INFORMATION

First name:		Last name :	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not what is your legal name?	
Date of birth (DD/MM/YY):        /        /	Sex : <input type="checkbox"/> M <input type="checkbox"/> F	Health Insurance card number:	
Street address :			
City :		Province :	
Home phone number: (        )	Other telephone: (        )		
Type of medical insurance :	<input type="checkbox"/> Public (RAMQ)	<input type="checkbox"/> McGill McGill ID:	<input type="checkbox"/> Private (automatic claim with client card) <input type="checkbox"/> Private (manual claim with medication receipt)

(Please hand out your health insurance card and your private insurance card if you have one)

### MEDICAL INFORMATION (If you need more space, write on back of form)

Do you have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, which?	Substance	Reaction (description of symptoms and approximate date)	
Do you take any medication (with or without prescription)? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, which ones?	Name	Dose	Since when?
Do you take any natural products or vitamins? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, which ones?	Name of product, strength, dose		
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of expected delivery (DD/MM/YY):        /        /		Are you breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, about how many cigarettes a day?		
Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have any particular health problems?			
Additional comments or suggestions (special services requires, pillboxes):			

Would you like us to transfer your prescriptions from any other pharmacy in Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, which pharmacy?	Telephone number: (        )
Complete file transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, which medication would you like transferred?

If you have any questions, do not hesitate to ask one of our friendly staff members!