

Soltani Medical Clinic  
#134-3030 Lincoln Ave Coquitlam BC V3B 6B4  
604 552 9140  
www.soltanimedicalclinic.com

## Botox Patient Registration Form

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Birth date: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email \_\_\_\_\_ Care Card#: \_\_\_\_\_

Would you like to receive text message appointment reminders? YES  NO

Do you have a family physician? YES NO

If so, please provide his/her name and when you had last seen this doctor.

How did you hear about our clinic? \_\_\_\_\_

### MEDICAL HISTORY

Please check off any relevant past medical history from the bottom list

Asthma	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Anxiety / Depression	<input type="checkbox"/>		

Do you have any known allergies to medications? \_\_\_\_\_

Please list your medications below or attach a copy of them to this form  
or indicate none: \_\_\_\_\_

Patient Signature: \_\_\_\_\_