Dr. Sunita Lal

Name: _____
(Last) (First)

Preferred Name: _____

Date of Birth: _____/_____/_____
Day Month Year

Address: _____
No. Street Apt.

_____
City Prov. Postal Code

Phone Numbers: Home: ( )_____

Work: ( )_____

Cell: ( )_____

Which number to call first? Please circle: HOME WORK CELL

Can we leave a detailed medical message? If yes, at what number?
Please circle: HOME WORK CELL

Email address checked regularly:
_____

Do you consent to email communication (appointment reminders, lab forms, simple medical information? YES NO

Family Physician: _____

Allergies: NONE _____

List of medications: _____

Which pharmacy should we fax prescriptions to? : _____