NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: ____
Last First Middle

Address: ____
Unit/Apt#/Street Name City Province Postal Code

Home Phone#: (_____)__________Work Phone#: (_____)__________ Mobile Phone#: (_____)__________

E-mail Address: ______________________ Gender: ________ Occupation: ______________

Date of Birth: _____ /_____ /______ Health Card #: ________________ Version Code: __________
D M Y

Emergency Contact: ____________________ Relationship: ____________ Phone#: (_____)________

Previous Family Physician: ______________________________ Phone#: (_____)________

MEDICAL HISTORY

Please check all that apply:

____ heart attack ____ heart disease ____ high blood pressure ____ diabetes
____ stroke ____ seizures ____ depression/anxiety ____ asthma
____ emphysema (COPD) ____ tuberculosis ____ cancer (type: _________) ____ HIV
____ other (details: ____)

Operations: ____

Medications being taken: ____

Family History of Significant Medical Illness: ______________________________

Any known Drug Allergies? Y N If Yes, what ______________________________

Do you have a Latex Allergy? Y N **PLEASE NOTE THIS IS NOT A LATEX FREE ENVIRONMENT.**

BY SIGNING THIS FROM, I HEREBY CERTIFY THAT I UNDERSTAND THE FOLLOWING:

1) THIS IS A **FAMILY PRACTICE** WHICH IS STAFFED BY A NUMBER OF DIFFERENT PHYSICIANS. DUE TO THE NATURE OF THIS TYPE OF PRACTICE, IT IS MY RESPONSIBILITY TO FOLLOW UP WITH THE CLINIC REGARDING ALL BLOOD WORK AND OTHER TEST RESULTS AND ANY REFERRAL APPOINTMENTS MADE ON MY BEHALF.
2) ALL NON-INSURED SERVICES MUST BE PAID FOR PRIOR TO SEEING THE PHYSICIAN. A SCHEDULE OF FEES IS AVAILABLE FROM RECEPTIONIST STAFF; AND
3) I CONSENT TO THE RELEASE OF MY MEDICAL RECORDS TO MY PREVIOUS FAMILY PHYSICIAN.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: ______________________________ Date: ______________