evolve ALLIED HEALTH

New Patient Intake Form

CONFIDENTIAL:

FULL NAME _____ BIRTHDATE month/day/year ____/____/____ AGE: ____

PREFERRED NAME _____ GENDER _____ MARITAL STATUS _____

ADDRESS _____ CITY_____ POSTAL CODE _____

HOME PHONE _____ CELL PHONE _____ EMAIL ADDRESS_____

HEALTH CARD NUMBER _____ ISSUING PROVINCE _____

EMERGENCY CONTACT NAME:_____ PHONE# _____ RELATIONSHIP: _____

CHILDREN LIVING AT HOME: FULL NAME _____ HEALTH CARD # _____ BIRTHDATE month/day/year ____/____/____

FULL NAME _____ HEALTH CARD # _____ BIRTHDATE month/day/year ____/____/____

FULL NAME _____ HEALTH CARD # _____ BIRTHDATE month/day/year ____/____/____

PRESENT HEALTH PROBLEMS: LIST YOUR MAIN HEALTH CONCERNS / SYMPTOMS

_____

_____

_____

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING ? (CIRCLE)

ANEMIA
HEPATITIS/LIVER DISEASE
HAYFEVER STOMACH
ULCER MEASLES
COLITIS
BLOOD CLOTS
GALLBLADDER PROBLEMS
ANGINA/CHEST PAIN
POLIO
STROKE
EPILEPSY
SMOKER? (Y OR N)
TUBERCULOSIS

RHEUMATIC FEVER
KIDNEY STONES ASTHMA
CANCER OF_____
MIGRAINE HEADACHES
MUMPS
ARTHRITIS/RHEUMATISM
HIVES
THYROID PROBLEMS
HEART DISEASE
DIABETES
ALCOHOL/DRUG ABUSE
MENTAL DISORDER

HEART ATTACK
HIGH BLOOD PRESSURE
PNEUMONIA
BLADDER/VAGINAL INFEC.
ABNORMAL PAP TEST
PROSTATE PROBLEMS
BLEEDING TENDENCIES
MONONUCLEOSIS
SEXUALLY TRANSMITTED DISEASE
ECZEMA
DEPRESSION
EATING DISORDER

SURGERIES (YEAR & TYPE) _____

_____

_____

HOSPITALIZATIONS (YEAR & REASON) _____

_____

_____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____

_____

OTHER CONDITIONS _____

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

FATHER (age)* _____ BROTHERS (ages)* _____

MOTHER (age)* _____ SISTERS (ages)* _____

* If deceased, Please list age at death and circle.

HAVE ANY OF THE ABOVE HAD THE FOLLOWING ? (CIRCLE)

DIABETES
HEART DISEASE
ALLERGIES
GOUT
ALCOHOLISM
CANCER

KIDNEY DISEASE
ASTHMA
ARTHRITIS
COLITIS
TUBERCULOSIS
STROKE

STOMACH ULCERS
HIGH BLOOD PRESSURE
NERVOUS BREAKDOWN
BLEEDING TENDENCIES
PSYCHIATRIC ILLNESS
GALLBLADDER PROBLEM

REPRODUCTIVE HEALTH

NUMBER OF CHILDREN_____ AGES_____

NUMBER OF PREGNANCIES _____ DELIVERIES_____

MISCARRIAGES_____ ABORTIONS _____

COMPLICATIONS _____

BIRTH CONTROL METHOD _____

LAST PAP TEST_____ MAMMOGRAM_____

KNOWN ALLERGIES (include medicines, pollens, animals, foods & chemicals): _____

_____

CURRENT MEDICATIONS (list all prescription & over the counter medicines, **vitamins, minerals, herbs** that you take):

_____

_____

_____

SIGN: _____ DATE: _____

Dear Patient,

There are uninsured service fees for items that are not covered under provincial MSP. These services are billed privately to the patient. Please ask for details at the front desk.

We have a 24 hour cancellation policy. We reserve the right to charge the patient for a missed appointment if notice is not given. **There will be a fee for each missed appointment.** Please call the office if you are unable to make your appointment.

Dr. _____ will review your intake form and determine your specific healthcare needs. If he/she is able to accommodate your needs within his/her practice, you will become his/her patient. However, while we do our best to accommodate all prospective patients, please be advised that completion of the new patient form does not guarantee the acceptance of your ongoing medical care. This will be determined at your meeting with the physician.

All patients are welcome to use our walk-in clinic.

PHARMANET

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act, R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the Pharmacy Operations and Drugs Schedule Act, S.B.C., 2003, c. 77 should it beproclaimed in force during the term of this Agreement.

I _____, authorize _____ and persons directly supervised by

Name of Patient (print) Name of Physician (print)

him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.
I understand that withdrawal of this consent must be in writing and delivered to the above-named physician.

CONSENT TO USE ELECTRONIC COMMUNICATIONS

The physician has offered to communicate using the following means of electronic communication:
Email ____ Video conferencing ____ Text messaging ____ Social media ____ Other (specify _____

I acknowledge that I fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication. I consent to the use of electronic communications and will follow instructions set out by staff in addition to any other conditions that the physician may impose on communications with patients using these methods of communication. I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the physician or staff using the services may not be encrypted. Despite this, I agree to communicate with the physician or the staff using these services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically.

SIGNATURE OF PATIENT: _____ **DATE:** _____

FOR OFFICE USE ONLY

DATE RECEIVED: _____ **ACCEPTED BY DR:** _____