HEALTH PLUS
Medical Centre

NEW PATIENT FORM

DATE:_____ DAY PHONE #:_____

DOCTOR REQUESTED:_____ WORK PHONE #:_____

LAST NAME:_____ REG #:_____

FIRST NAME:_____ P.H.I.N. #:_____

D.O.B. (DAY/MO/YR):_____

ADDRESS:_____ POSTAL CODE:_____

EMAIL ADDRESS: (for appt. reminders)_____

DO YOU PRESENTLY HAVE A DOCTOR? Please circle one YES / NO

IF YES, WHO IS YOUR FAMILY DOCTOR:_____

Do You Have Any Allergies to Medications?_____

DO YOU USE NARCOTICS REGULARLY? (EX. MORPHINE, PERCOCET, T3)
Please circle one. YES / NO

Medications:_____

Please circle one: Smoker / Non-Smoker / Ex. Smoker

Please circle one: Family History: Heart Disease / Cancer

PLEASE GIVE A BRIEF MEDICAL HISTORY:

Please check ALL that apply:

- ❑ Alzheimer's Disease
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Chronic Fatigue Syndrome
- ❑ Depression
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Long Term Back Pain
- ❑ Long Term Pain
- ❑ Parkinson's Disease
- ❑ Psychiatric History

Please include any other conditions if not listed here:

_____

_____

_____

_____

This form is for information purposes only and not an agreement to becoming a new patient for a doctor. You will be advised by telephone if accepted to schedule a meet and greet appointment. A meet and greet appointment is for information gathering ONLY. If you have medical concerns please make another appointment.

Please note, you will be charged for any missed appointments without 24 hour notice, and any phone or fax prescription renewals.

Signature:_____