evolve
ALLIED HEALTH

New Patient Intake Form

CONFIDENTIAL:

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

PREFERRED NAME ______________ SEX _________ 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	RHEUMATIC FEVER	HEART ATTACK
HEPATITIS/LIVER DISEASE	KIDNEY STONES ASTHMA	HIGH BLOOD PRESSURE
HAYFEVER TUBERCULOSIS	CANCER OF_________	PNEUMONIA
STOMACH ULCER	MIGRAINE HEADACHES	BLADDER/VAGINAL INFEC.
MEASLES	MUMPS	ABNORMAL PAP TEST
COLITIS	ARTHRITIS/RHEUMATISM	PROSTATE PROBLEMS
BLOOD CLOTS	HIVES	BLEEDING TENDENCIES
GALLBLADDER PROBLEMS	THYROID PROBLEMS	MONONUCLEOSIS
ANGINA/CHEST PAIN	HEART DISEASE	SEXUALLY TRANSMITTED
POLIO	DIABETES	DISEASE
STROKE	ALCOHOL/DRUG ABUSE	ECZEMA
EPILEPSY	MENTAL DISORDER	DEPRESSION
SMOKER? (Y OR N)		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	KIDNEY DISEASE	STOMACH ULCERS
HEART DISEASE	ASTHMA	HIGH BLOOD PRESSURE
ALLERGIES	ARTHRITIS	NERVOUS BREAKDOWN
GOUT	COLITIS	BLEEDING TENDENCIES
ALCOHOLISM	TUBERCULOSIS	PSYCHIATRIC ILLNESS
CANCER	STROKE	GALLBLADDER PROBLEM

WOMEN ONLY - CHILDBIRTH HISTORY

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 ____ 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: ____________________________________