# NEW PATIENT INTAKE FORM

FIRST NAME: PREVIOUS FAMILY PHYSICIAN:
LAST NAME: DOB: Health Card #:
CONTACT TEL: E-MAIL: Health Card Version Code :
ADDRESS:
CITY: POSTAL CODE: COUNTRY:

**EMERGENCY CONTACT INFO:**
Relation
Relation

Is it OK to contact you by e-mail? Yes No
Contact number:
Contact number:

**PAST MEDICAL HISTORY**:

**PAST SURGERIES AND PROCEDURES**:
(please include dates)

**FAMILY HISTORY:** please indicate any significant medical issues among family members and who they affect
(e.g. Diabetes, Cancer, High blood pressure, heart attack, stroke, lung disease, etc)

**PREVENTATIVE HEALTH/LIFESTYLE:**
(please circle one)
Do you smoke? Yes No
Do you drink alcohol? Socially / Regular / Never
Do you use any recreational drugs? Yes No
Family dependents:
Do you exercise regularly? Yes No
If yes, describe:

**EDUCATION/OCCUPATION:**
**HOBBIES/INTERESTS:**
**RELIGION/FAITH:**

**PRESCRIPTION MEDICATIONS:**

**NON-PRESCRIPTION MEDICINES:**
(Over- the-counter, herbal, vitamins, other etc)

**ALLERGIES:**
Reaction:
Reaction:
Reaction:
Reaction:

**When did you last have the following;**

- o Pap Smear
- o Mammogram
- o Hemoccult- FIT
  (stool test for colon cancer screen)
- o Colonoscopy
- o Prostate Exam
- o Complete Physical
- o Flu Shot
- o Pneumonia
- o Tetanus
- o HPV
- o Shingles
- o Hepatitis A
- o Hepatitis B
- o Other

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

1) THIS IS A FAMILY PRACTICE STAFFED BY SEVERAL 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 BEFORE SEEING THE PHYSICIAN. A SCHEDULE OF FEES IS AVAILABLE FROM THE RECEPTIONIST STAFF.

3) I CONSENT TO THE RELEASE OF MY MEDICAL RECORDS TO/FROM MY PREVIOUS FAMILY PHYSICIAN.

4) BY GIVING MY EMAIL AND PHONE NUMBER, I GIVE CONSENT TO RECEIVE EMAIL COMMUNICATION AND VOICE MESSAGES.

5) A 24-HOUR NOTICE IS REQUIRED TO CANCEL AN APPOINTMENT. OTHERWISE, A FEE OF 40 $ IS REQUIRED PER 1 MISSED APPOINTMENT. FAILURE TO PAY FOR THE MISSED APPOINTMENTS, OR RECURRENT MISSED APPOINTMENT, CAN RESULT IN YOUR DISCHARGE FROM THE PRACTICE

6) I UNDERSTAND THAT FILLING OUT THIS FORM DOES NOT MEAN I AM A PATIENT AT THIS CLINIC, AND AN INITIAL APPOINTMENT WITH THE DOCTOR (MEET AND GREET) IS ALSO NEEDED TO REGISTER AT THE CLINIC.

7) THE CLINIC PROMISE TO TREAT YOU WITH CONSIDERATION AND RESPECT, AND WE ASK FOR THE SAME COMMITMENT FROM YOU.

SIGNATURE: _____

DATE: _____

PLEASE FILL THE FORM FOR EACH INDVIUAL PATIENT THAT WISH TO REGISTER IN OUR CLINIC.

Scan and email us the filled forms at :

gatewaymedicalcambridge@gmail.com