RIVERDISTRICT MEDICAL

Patient Intake Form

Clinic Patient Information

Last Name: _____First Name: _____Date of Birth_____

Health Card #:_____Occupation:_____

Address:_____

City:_____Province:_____ Postal Code:_____

_____ _____

Home Phone Number Cell Number

*Please indicate which number can be used for primary contact purposes.

May we leave information on your voicemail, such as appointments, etc? At Home yes/no Cell yes / no

In case we are unable to reach you by phone, may We attempt to contact you by email? _____

Email

Emergency Contact

_____ _____ _____

Full Name Relationship Primary Contact Number

Medical History

Allergies/Drug Intolerance _____

Medical Conditions: _____

Past Issues: _____

Past Surgeries/Procedures: _____

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Family History of Medical Conditions (include family member)

_____

_____

Medication

Current (please include dosage): _____

_____

Past Medication: _____

Other Notes: _____

Previous Family Physician/Clinic_____

Preferred Pharmacy: _____

As part of our Clinic Policy

24 hours are required for cancellation or rescheduling of appointments otherwise a $50 fee will be applied.

By signing this form you are acknowledging that you are aware of our clinic policies and fee schedules

_____ _____

Patient Signature Date