FIRESIDE FAMILY HEALTH MEDICAL CLINIC
Phone: (587)-551-3348
7111-50 Fireside Gate, Cochrane, AB, T4C 2A3
www.firesidefamilyhealth.ca

NEW PATIENT INTAKE FORM

Last Name: ______________________________ First Name: ________________________ Middle Initial: _____

Gender: ________ DOB (yyyy/mmm/dd): (_____/_____/_____), PHN (Personal Health Number): ________________

Address: __________________________________ City: ________________ Province: ___ Postal Code: __________

Home #: (______) _______-_________ Cell # (______) ______-__________

Email Address: _____________________________________ Is it okay to contact you via email? Yes / No __________

Emergency Contact: _________________________Relation: ______________ Contact #: (______) _______-_______

1. Patients are expected to inform the clinic of any changes in their address and contact information as soon as possible.
2. <u>We require 24 hours' notice to cancel a booked appointment.</u> We reserve the right to charge for no shows per Alberta Medical Association guidelines.
3. <u>Threatening behaviour and abuse of staff, health care providers or other patients will not be tolerated.</u>
4. Patients are encouraged to set up an appointment with their physician for prescription renewal approximately 2 weeks prior to prescriptions running out.
5. Please avoid adding another family member's concerns during your consultation. Each patient requires their own appointment.
6. We need to book the correct type of appointment for you, so please indicate the reason for the appointment when booking with the reception staff.
7. <u>We ask that you register with MyHealthAccess (myhealthaccess.ca).</u>
   We encourage you to use this online booking system which will allow for confidential correspondence with your physician, as well as booking, rescheduling, and canceling of appointments. Please set up a separate account for each family member joining our clinic.

8. Same day acute appointments must be booked with one of the reception staff.
9. To ensure timely and appropriate follow up, please book an appointment to see your doctor for 2 weeks after completing the requested test. At your doctor's discretion, test results may be provided over the phone.
10. To reach the after-hours physician, please call Health Link at 811.
11. Alberta Health does not cover certain services and a fee may be charged for these uninsured services according to Alberta Medical Association guidelines. The reception staff will inform the patient of the fee at the time of booking. A list of uninsured services can be found on the Alberta Medical Association website. The office staff and/or management can provide a more detailed breakdown of clinic policies, guidelines, and uninsured services.

- ☐ I have read and understand the above policies. By signing this form, I acknowledge my acceptance of these policies.
- ☐ I give consent to my doctor to contact me via MyHealthAccess to provide medical advice.

Print Name: _______________________ Signature: ______________________________ Date: _______________
(Or Parent / Legal Guardian)

Patient Name: ____

Medical History

Do you have or have you ever had any of the following?

- ❑ Stroke
- ❑ Epilepsy (Seizures)
- ❑ Heart problems
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Artificial heart valves
- ❑ Pacemaker / implant defibrillator
- ❑ Asthma / COPD
- ❑ Hay fever
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Kidney disease
- ❑ Liver disease / Hepatitis
- ❑ Thyroid disease
- ❑ Stomach ulcers
- ❑ Crohn's IBS
- ❑ Eczema
- ❑ Cancer
- ❑ Osteoporosis
- ❑ Rheumatoid arthritis
- ❑ Artificial joints
- ❑ Sexually Transmitted Disease
- ❑ Autoimmune disease
- ❑ HIV / AIDS
- ❑ Depression / anxiety

Other medical conditions (please list): ____

Surgical History

Name of Surgery	Name of Surgeon & Hospital	Year of Surgery
1.		
2.		

Current Medications

Are you allergic to any medications? Yes / No Please explain: ____

Are you currently on opioid/restricted medications? Yes / No If yes, please list: ____

Please list current medications:

Name of Drug	**Dosage**	**How long have you been on this?**

Preferred pharmacy: ____

Personal / Social History

Do you exercise regularly: Yes / No Describe: ____

Do you smoke? ☐Social ☐Regular ☐Previously ☐ Never Describe: ____

Do you drink alcohol? ☐Social ☐Regular ☐Previously ☐Never Describe: ____

Do you currently use any recreational drugs? Yes / No Have you ever used injectable drugs? Yes / No

Have you ever had any adverse reactions to dental anesthesia (freezing)? Yes / No ____

Are you allergic to Latex? Yes / No Other allergies / sensitivities? Yes /No ____

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, etc.):

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