



NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Date _____

Health Card Number _____ Province _____

Select Date of Birth _____ Pronoun _____ Sex _____

Last Name _____ Middle Name _____

First Name _____ Preferred Name _____

Address _____

City _____ Province _____ Postal Code _____

Cell Phone _____ Home Phone _____

Email _____ Occupation _____

Preferred Pharmacy _____

Pharmacy Phone Number _____ Pharmacy Fax Number _____

Are you currently using Opioid/Restricted medications? ☐ Yes ☐ No

EMERGENCY CONTACT

Name _____

Phone Number _____ Relationship _____

ALLERGIES

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO

If **yes**, please specify below:

☐ Xylocaine/Lidocaine ☐ Iodine ☐ Acetaminophen (Tylenol)

☐ Latex ☐ Stanhexidine ☐ Ibuprofen (Advil)

☐ Other Allergies (Please specify) _____

NEW PATIENT INTAKE FORM CONT'D

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- | | | |
|---|---|---|
| ☐ Stroke | ☐ Hay Fever | ☐ Ezcema |
| ☐ Epilepsy | ☐ Pneumonia | ☐ Cancer |
| ☐ Heart Problems | ☐ Tuberculosis | ☐ Osteoporosis |
| ☐ High Chloestrol | ☐ Diabetes | ☐ Rheumatoid Arthritis |
| ☐ High Blood Pressure | ☐ Kidney Disease | ☐ Artifical Joints |
| ☐ Heart Attack | ☐ Liver Disease/Hepatitis | ☐ Sexually Transmitted Disease |
| ☐ Artifical Heart Valves | ☐ Thyroid Disease | ☐ Autoimmune Disease |
| ☐ Pacemaker/Implant | ☐ Stomach Ulcer | ☐ HIV/AIDS |
| ☐ Defibrillator | ☐ Crohn's Disease/Inflammatory | ☐ Depression/Anxiety |
| ☐ Asthma/COPD | ☐ Bowel Disease | |
| ☐ Other medical coniditions: _____ | | |

SURGERIES

1. Name of Surgery _____
When _____ Where _____
2. Name of Surgery _____
When _____ Where _____

CURRENT MEDICATIONS

PERSONAL/SOCIAL/FAMILY HISTORY

- Do you exercise regularly? ☐ Yes ☐ No Describe _____
- Do you smoke? ☐ Socially ☐ Regularly ☐ Previously ☐ Never
- Do you drink alcohol? ☐ Socially ☐ Regularly ☐ Previously ☐ Never
- Do you use recreational drugs? ☐ Yes ☐ No
- Do you or have you ever used injectable drugs? ☐ Yes ☐ No
- Have you ever had any adverse reaction to dental anaesthesia (freezing)? ☐ Yes ☐ No

Family Medical History:

I hereby confirm that the information provided is true and accurate, and that I have read and agree to the clinic policies.

Print Name _____ Signature _____