PATIENT INTAKE FORM

Clinic Name: _____ Patient ID: _____

Patient Personal Information:

Full Name: _____

Date of Birth (YYYY-MM-DD): _____

Gender: _____ Phone Number: _____

Email Address: _____

Home Address: _____

Emergency Contact Information:

Name: _____

Relationship: _____

Phone Number: _____

Health Insurance Information:

Provider Name: _____

Policy Number: _____

Group Number: _____

Medical History:

Please list any chronic illnesses, ongoing medical conditions, or significant past medical history relevant to your healthcare:

_____

Current Medications:

List all medications, including dosage and frequency, that you are currently taking:

_____

Allergies:

List any known allergies, including medication, food, or environmental allergies:

_____

Lifestyle and Habits:

Please provide information about tobacco, alcohol, recreational drug use, exercise habits, and diet:

_____

Consent and Acknowledgments:

I hereby consent to the collection, use, and disclosure of my personal health information in accordance with applicable Canadian privacy laws. I acknowledge that this information is necessary for the provision of healthcare services and will be handled confidentially. I understand my rights to access and correct my health information and to withdraw consent to the extent permitted by law. I affirm that the information provided above is accurate and complete to the best of my knowledge.

PATIENT'S SIGNATURE

Signature: _____

Date: _____

HEALTHCARE PROVIDER'S SIGNATURE

Signature: _____

Date: _____