

# 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**

**HEALTHCARE PROVIDER'S SIGNATURE**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

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