Integral Medical Centre's Patient Demographic

CONTACT INFORMATION:

Today's Date:____________________

LAST NAME: ____________________ **FIRST NAME:** ____________________

HEALTH NO #: ____________________ **Birthday:** ________________ (mmm/dd/yyyy) **Age:** ______

Gender Identity: ◯ Male ◯ Female ◯ Other: ________________

Home Address: ______________________________ **City:** ____________

Postal Code ____________ **Home Phone**: __________________ ◯ No Home Phone

Cell Phone: ________________ **Work Phone**: ________________

Email: ______________________________

Insurance: Please circle if your visit pertains to **WCB:** Claim number: ____________________

SGI Injury Claim Number:___________ | **RCMP** ID NUMBER________________ | **DVA I**D Number_________________.

EMERGENCY CONTACT INFORMATION:

Spouse OR Next of Kin OR Both Parent's Names (for patients under 18 years of age).

Name: ______________________________ **Phone:** ________________

Relationship: ____________________

MEDICAL INFORMATION:

Family Physician: Dr. ____________________ **Phone:** __________________

◯ I do not have a family doctor currently. ☐ I give consent to Telephone / Virtual Consults

Preferred Pharmacy Location: ◯ **Dieppe Pharmacy (Dewdney)** ◯ **Others (Pls. Specify)** ________________

Immunizations up to date? ◯ Yes ◯ No ◯ Unknown

Are you allergic to any Medications or Non-Drug items? ◯ Yes ◯ No If Yes, please explain/list:________________

____

Is there any significant medical history we should know about? ____________________

____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If Yes, please describe: ________________

____

Family History: ____

Do you smoke (or for patients under the age of 18, is there any history of parental smoking)?

◯ Yes ◯ No If Yes, please list: ______________________________

Do you have pets: ◯ Yes ◯ No If Yes, please list: ______________________________

Reason for your visit today?: ______________________________

To the best of my knowledge, the questions on this form have been accuratly answered. I understand that providing inccorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in medical status.

Signature of patient, parent or guardian: ______________________________Date: ____________