PATIENT INTAKE FORM-- Fleetwood Family Physicians

Patient Name: _____ Date of Birth:___/___/___

Age: _____ Gender: _____ Weight: _____ Height:_____Weight:_____

Care Card #: _____**Email:** _____

Home Address: _____ Postal Code: _____

Numbers: **Cell:** _____ Home: _____ Family Doctor: _____

Medical Information

Allergies(list med and reaction)_____ _____

Current Medication/s & Dosages: _____ _____

_____ _____ _____ _____ _____

Please check the ones that are applicable to your Past Medical History:

- ❑ Blood Clots
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Thyroid Disease
- ❑ Migraine Headaches
- ❑ Seizures
- ❑ Digestive Issues
- ❑ Fractures
- ❑ Anemia
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Cancer
- ❑ Hepatitis
- ❑ HIV
- ❑ Other serious past conditions, illnesses,surgeries, injuries and/or hospitalizations & dates:

Vaccines-(checkmark if have received) Pneumovax_____TDAP_____Shingles_____Flu Vaccine_____

Family History (please indicate family member affected)

_____ _____

_____ _____

Social History

Marital status (circle one) married, single, common law, divorced.

Occupation: Alcohol Use: Y/N? How many 1 oz. drinks per day?___ Per week?_____

Cigarette Use: Y/N? How many packs per day?__ For how long?_____ Recreational Drugs: Y/N?

Informed Consent to Treatment (must be reviewed prior to being accepted at the clinic)

I give Fleetwood Family Physicians or its assignee's the authority to review my medication list on Medinet/Pharmanet and obtain relevant medical records from other healthcare providers/institutions.

I understand that after-hours emergencies need to be taken care of in the Emergency Room and that if I need urgent medical care that I need to go to a walk-in clinic or the Emergency room.

I will not compound multiple medical issues in an appointment as this leads to poor care and not enough time to discuss issues appropriately. I will make an agenda with my doctor for all my issues at the start of the appointment.

I am responsible for ALL test results. I will make separate follow up appointments to discuss all test results with the doc.

I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the payment of a cancellation fee ($50 charge) prior to my next visit. Any overdue fees must be paid prior to seeing the doctor. I understand that if I have 3 no-shows to this office we have the right to close your file.

I agree to email, text, and telehealth communication and understand that my info can be intercepted and sent/used by another individual in harmful ways.

Patients acknowledge that they may occasionally be assessed and treated by a medical learner (ie resident/nurse practitioner student) as this is a clinic involved in training future health care providers.

I agree to Respect the Clinic staff and refrain from any form of verbal or physical aggression or harassment

A positive therapeutic relationship relies on mutual trust and respect between the patient and the doctor/staff. If this foundation is lost, a productive therapeutic relationship may no longer be possible, and either the patient or the doctor may choose to terminate this doctor-patient relationship which will involve the patient to seek medical care elsewhere.

I have read, understood and agree with the above statements.

Signature: _____ Date: _____