



## MEDCARE CLINICS @ SCOTT STREET

387 Scott Street, Unit A2C • St. Catharines, Ontario • L2M 3W2 - Canada

Phone: (905) 646 8383 • Fax: (905) 646 0202

Email: [stc@medcareclinics.com](mailto:stc@medcareclinics.com) • Web: [www.medcareclinics.com](http://www.medcareclinics.com)

### New Patient Questionnaire

Please complete this form prior to seeing the healthcare provider. This form is designed to streamline your appointment and to reduce the likelihood that important issues are overlooked.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Marital status: \_\_\_\_\_ Country of birth: \_\_\_\_\_

Current occupation: \_\_\_\_\_ Email address: \_\_\_\_\_

Address: \_\_\_\_\_ Unit/Suite #: \_\_\_\_\_ Province: \_\_\_\_\_

City: \_\_\_\_\_ Postal code: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Current/Previous Family Doctor's Name & Phone #: \_\_\_\_\_

Pharmacy name & phone #: \_\_\_\_\_

Children (*please provide names, gender, year of birth & any serious illness*):

\_\_\_\_\_  
\_\_\_\_\_

Current/Past medical conditions (*e.g. high blood pressure, high cholesterol, irritable bowel syndrome, depression, childhood asthma, eczema, broken wrist, etc.*):

\_\_\_\_\_  
\_\_\_\_\_

Previous/resolved medical conditions:

\_\_\_\_\_  
\_\_\_\_\_

Surgeries/procedures or hospitalizations (*please include the year and details of any time you had surgery, or were admitted to the hospital overnight*):

\_\_\_\_\_  
\_\_\_\_\_

Prescription Medications (*include name of medication, dose/strength, and how often you take it, e.g. lipitor 10mg once per day, ramipril 5mg two times per day*):

\_\_\_\_\_  
\_\_\_\_\_

Over the counter and herbal products:

\_\_\_\_\_



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Allergies (include the trigger & reaction you get, e.g. penicillin - rash, peanuts - hives):

Alcohol History: [ ] Beer [ ] Hard Liquor Number of drinks/week: \_\_\_\_\_

Smoking History: [ ] Current Smoker - Number of cigarettes per day \_\_\_\_\_  
[ ] Previous smoker [ ] Never smoked  
[ ] Marijuana (recreational) [ ] Marijuana (medicinal)  
[ ] Recreational drugs, please specify \_\_\_\_\_

**Preventative Screening** (Please indicate when your last screening was done – if applicable):

FOBT/Colonoscopy: \_\_\_\_\_ Bone Density: \_\_\_\_\_

Prostate: \_\_\_\_\_ Mammogram: \_\_\_\_\_ PAP Smear: \_\_\_\_\_

**Family medical history** (Please indicate family member and age at diagnosis):

Heart disease, heart attack: [ ] NO [ ] YES  
Family Member and Age at Diagnosis: \_\_\_\_\_

Stroke: [ ] NO [ ] YES  
Family Member and Age at Diagnosis: \_\_\_\_\_

High blood pressure: [ ] NO [ ] YES  
Family Member and Age at Diagnosis: \_\_\_\_\_

Diabetes: [ ] NO [ ] YES  
Family Member and Age at Diagnosis: \_\_\_\_\_

Breast, ovarian, colon or prostate cancer: [ ] NO [ ] YES  
Family Member and Age at Diagnosis: \_\_\_\_\_

Mental Illness (e.g. anxiety, depression, bipolar, schizophrenia): [ ] NO [ ] YES  
Family Member and Age at Diagnosis: \_\_\_\_\_

Other: \_\_\_\_\_

### Disclaimer & Policies

All personal and health information is kept strictly confidential and secure. No medical or health information will be provided over the phone. MedCare Clinics will not disclose any personal or health information to any third party (without prior consent). MedCare Clinics enforces a strict cancellation policy to maximize patient access to their healthcare provider, and therefore a 24-hour notice is required for ALL appointment cancellations. A cancellation/no-show fee will be charged for all missed appointments without 24-hour notice. All cancellations must be requested during clinic hours. For all medical services, a valid OHIP card must be presented before each visit to receive medical care. In the event an expired or invalid OHIP card is presented, patients will be billed directly for the medical appointment before the appointment. This payment is non-refundable. For all medical services not covered by OHIP, payment is required at the time of service. MedCare Clinics provides all patients with the required receipts and documents for submission to insurance companies or any 3<sup>rd</sup> party coverage providers. Please note that each patient's insurance agreement is an agreement between themselves and the insurance company directly. In the event that any insurance company or 3<sup>rd</sup> party coverage provider does not completely reimburse or even rejects any health service claim provided at MedCare Clinics, the patient is still responsible for all fees. I acknowledge and understand the role of a physician assistant and a nurse practitioner and consent to be seen and have healthcare provided to me by a physician assistant or a nurse practitioner. I acknowledge that I have read and fully understand this form, disclaimers, and policies. I consent to the conditions outlined herein, as well as any other instructions that the physician may impose to communicate with me as well as all of MedCare Clinic's policies, terms and regulations. By signing this document, I understand that I agree to waive any and all claims (including but not limited to, malpractice) that I have or may have in the future against the MedCare Clinics, its directors, owners/operators, employees, affiliates, health professionals, physicians (collectively the "releasees"). I agree to release the releasees from any and all liability for any loss, damage or injury that my next of kin or I may suffer as a result of the improper release of medical information, including negligence, breach of contract, malpractice, or breach of any statutory or other duty of care. I also authorize MedCare Clinics to contact me via email for news and updates in regards to the clinic and its services.

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

Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ (Self, Parent, Guardian)