MEDCARE CLINICS @ WALMART VAUGHAN NORTHWEST

3600 Major MacKenzie Drive West, Unit # 3 • Vaughan, Ontario • L4H 3T6, Canada
Phone: (905) 303 4003 • Fax: (905) 303 4305
Email: vaughan@medcareclinics.com • Web: 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. Completion of this form does not confirm a doctor-patient relationship. 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 3rd 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 3rd 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)

OFFICE USE ONLY: Scanned to EMR: [ ] All details entered into EMR: [ ]