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 • 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:

_____

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

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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

All personal and health information is kept confidential and secure in accordance with applicable laws. MedCare Clinics operates under a shared care model. Completion of this form does not confirm a doctor-patient relationship and you acknowledge that you will not be assigned to one specific provider. 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 express prior consent) except to those individuals necessary for the provision of medical services in accordance with applicable law. 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 fee will be charged for all missed appointments without 24-hour notice. All cancellations must be requested during clinic hours. For all medical/physician services, a valid OHIP card must be presented at 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 rejects any claim provided at MedCare Clinics, the patient remains 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 services provided to me by a physician assistant or a nurse practitioner working under the direct supervision of a licensed physician. I acknowledge that I have read and fully understand this form, disclaimers, and policies listed on the MedCare Clinics' website. I consent to the conditions outlined herein, as well as any other instructions that the healthcare providers may impose to communicate with me as well as all of MedCare Clinic's policies, terms and conditions. By signing this document, I agree to waive all claims (including but not limited to, medical malpractice) that I have or may have in the future against MedCare Clinics. I agree to release MedCare Clinics from all liability for any loss, death, damage or injury that my next of kin or I may suffer for any negligence, breach of contract, malpractice, or breach of any statutory or other duty of care. I also expressly consent and authorize MedCare Clinics to contact me via email for news and updates in regards to the clinic and its services.

[1]All references to MedCare Clinics include its directors, officers, physicians, employees, agents and affiliates or other related companies (including any successor companies to MedCare Clinics).

Name: _____ Signature: _____

Date: _____ Relationship to patient: _____ (Self, Parent, Guardian)

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