MEDCARE CLINICS @ GEORGETOWN MEDICAL CENTRE

333 Mountainview Road South, Unit 2 • Georgetown, Ontario • L7G 6E8, Canada
Phone: (905) 877-0877 • Fax: (905) 877-4455
Email: georgetown@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 visit and to reduce the likelihood that important issues are overlooked.

Full name: _____ Date of birth: _____

Marital status: _____ Gender (at birth): _____

Current occupation: _____ Country of birth: _____

Address: _____ Unit/Suite #: _____ Province: _____

City: _____ Postal code: _____ Phone #: _____

Email address: _____ How did you hear about us: _____

OHIP Health Card # *(including version code):* _____ Expiry: _____

Emergency Contact Name: _____ Relation:_____ Phone #: _____

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

Pharmacy name & phone #: _____

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

_____

Disclaimer & Consent

I acknowledge and agree that all personal and health information provided to MedCare Clinics will be kept confidential and secure in accordance with applicable laws and will only be disclosed to individuals involved in my care or as otherwise permitted by law. I understand that MedCare Clinics operates under a shared-care model, that completion of this form does not establish an exclusive doctor–patient relationship, and that I may receive care from physician assistants, clinical assistants, nurses, scribes, and nurse practitioners under the supervision of a licensed physician. I consent to the possible use of AI-assisted scribe technology to help document my visit, understanding that my privacy will be maintained in accordance with applicable regulations. I acknowledge that appointment cancellations require at least 24 hours' notice during clinic hours to avoid cancellation fees. For all medical services not covered by OHIP, payment is required at the time of service, with such payments being non-refundable. I accept that MedCare Clinics will provide receipts for insurance purposes, but that reimbursement is solely between myself and my insurer, and I remain responsible for all outstanding amounts. In the event that an expired or invalid OHIP card is presented, I acknowledge that payment in full will be required prior to the provision of medical services, and that any refund issued will be limited to the applicable amount, excluding all administrative fees. I acknowledge that MedCare Clinics itself does not provide patient care or medical services. The facility serves solely as the location where independent physicians deliver medical assessments and consultations. All patient care is provided at the physician's sole discretion and under their exclusive responsibility, in accordance with their physician services agreement with MedCare Clinics. I confirm that I have read, understood, and agree to the disclaimers, terms of use, patient responsibilities, and policies listed on the MedCare Clinics website, and by signing this form I release MedCare Clinics, its directors, officers, physicians, employees, agents, affiliates, and successors from all liability, including but not limited to negligence, malpractice, or breach of duty, for any loss, damage, injury, or death that I or my next of kin may suffer. I further consent to being contacted by email or text message for clinic updates, appointment reminders, and information about services.

Name: _____ Signature: _____

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

Current/Past 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)*:

_____

_____

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Medications, including prescriptions, herbal or over the counter 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):

_____

_____

Alcohol History: [ ] Beer [ ] Wine [ ] Hard Liquor Number of drinks/week: _____

Smoking History:
[ ] Current Smoker - Number of cigarettes per day _____
[ ] Previous smoker [ ] Never smoked
[ ] Cannabis (recreational) [ ] Cannabis (medicinal)
[ ] Vaping
[ ] 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: _____

Cancers: [ ]NO [ ]YES
Family Member and Age at Diagnosis: _____

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

Any other relevant medical information:

_____

_____

_____

_____