



Smoking History:

[]	Current Smoker - Number of cigarettes per day _____
[]	Previous smoker [] Never smoked
[]	Cannabis (recreational) [] Cannabis (medicinal)
[]	Vaping
[]	Recreational drugs, please specify _____



MEDCARE CLINICS @ WALMART HAMILTON

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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:

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)