



## MEDCARE CLINICS @ WALMART MARKHAM

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### 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:

Alcohol History:      ☐ Beer      ☐ Wine      ☐ Hard Liquor      Number of drinks/week: \_\_\_\_\_

Smoking History:      ☐      Current Smoker - Number of cigarettes per day \_\_\_\_\_

|     |                 |     |              |
|-----|-----------------|-----|--------------|
| [ ] | Previous smoker | [ ] | Never smoked |
|-----|-----------------|-----|--------------|

|     |                         |     |                      |
|-----|-------------------------|-----|----------------------|
| [ ] | 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: