NEW PATIENT INFORMATION FORM

Date:_____

PERSONAL INFORMATION:

Do you currently have a family Doctor: ☐ No ☐ Yes: _____

First name: _____ **Last Name:** _____

Address: _____

City/Province: _____/_____ **Postal Code:** _____

Cell Phone: _____ **Email Address:** _____

Home phone: _____ **Work Phone:** _____

Pharmacy: _____ **Pharmacy PH No:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: DD _/ MM _/ YY **Age:** _____

Health Card No.: _____ **Province:** _____

Emergency Contact: _____ **Phone No.:**_____

Allergies:_____

_____

Medications:_____

_____

_____

Past Illness/Operations:_____

_____

_____

FAMILY HISTORY	*SOCIAL HISTORY*
Diabetes:	Occupation:
High Blood Pressure:	Children:
Cancer:	Active/Retired:
Heart Disease:	Smoker: ☐ Yes ☐ No / How Often:
Other:	Alcohol: ☐ Yes ☐ No / How Often: