

# NEW PATIENT REGISTRATION FORM



## Patient Demographics:

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Sex at Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Care Card #: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Languages Spoken: \_\_\_\_\_  
Profession: \_\_\_\_\_

## For Patients Under the Age of 18:

Mother's First Name: \_\_\_\_\_ Mother's Last Name: \_\_\_\_\_  
Father's First Name: \_\_\_\_\_ Father's Last Name: \_\_\_\_\_

## Contact:

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Province: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_

Do you consent to electronic communication through patient portal and/or email if needed? ☐ Yes ☐ No

## Preferred Pharmacy:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_

## Emergency Contact:

First Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Last Name: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Relationship: \_\_\_\_\_

## Health Care Providers

Do you currently have a family physician? ☐ Yes ☐ No

Please provide name and address of current (if **yes**), or previous (if **no**) family physician

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If yes, reason you are looking for a new family physician

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Do you have any additional physicians or caregivers that you are currently seeing or would like us to know about?

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## Medical History

List all current medical problems

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List all past medical history

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List all surgical history. Please include date, reason and hospital.

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List any psychiatric history

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List any obstetrical history

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List any other hospitalization history. Please include date, reason and hospital.

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**Childhood Illnesses** – Select all that apply

☐ Measles

☐ Mumps

☐ Rubella

☐ Chicken Pox

☐ Rheumatic Fever

☐ Polio

☐ None

☐ Other: \_\_\_\_\_

## Preventive Activity

List all your preventative activities, frequency and start date.

| Preventative Item<br>Eg; PAP, Colonoscopy, etc. | Frequency<br>Eg; Every 3 years | Date of Last Test<br>MM/DD/YYYY |
|-------------------------------------------------|--------------------------------|---------------------------------|
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## Allergies And Intolerances

Please list any drug allergies \_\_\_\_\_  
Please list any intolerances \_\_\_\_\_

## Social Habits

Do you Drink Alcohol?    ☐ Yes    ☐ No    If yes, how many drinks per day? \_\_\_\_\_  
Do you smoke?    ☐ Yes    ☐ No    If yes, how much do you smoke per day? \_\_\_\_\_  
Do you use recreational or street drugs?    ☐ Yes    ☐ No    If yes, what do you use and how often? \_\_\_\_\_  
Do you drink coffee?    ☐ Yes    ☐ No    If yes, how many cups per day? \_\_\_\_\_

## Alerts & Special Needs

Are there any special needs that we should be aware of to ensure that we provide you with the best care possible?

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## Family History

List any significant medical health problems and date of death if applicable.

Father \_\_\_\_\_  
Mother \_\_\_\_\_  
Siblings \_\_\_\_\_  
Children \_\_\_\_\_  
Other \_\_\_\_\_

## Immunizations

Please indicate month and year of last vaccination for the following:

Tetanus \_\_\_\_\_  
Influenza \_\_\_\_\_  
Pneumonia \_\_\_\_\_  
Hepatitis \_\_\_\_\_  
Chicken Pox \_\_\_\_\_  
MMR \_\_\_\_\_

List any additional vaccination you have received

\_\_\_\_\_  
\_\_\_\_\_

## Active Medication

Please list all prescribed medication.

| Name of Drug<br>Eg; Metformin | Strength<br>Eg; 200 mg | Frequency<br>Eg; 2x daily | Name of Drug<br>Eg; Metformin | Strength<br>Eg; 200 mg | Frequency<br>Eg; 2x daily |
|-------------------------------|------------------------|---------------------------|-------------------------------|------------------------|---------------------------|
|                               |                        |                           |                               |                        |                           |
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|                               |                        |                           |                               |                        |                           |

Please list any and all over-the-counter drugs

\_\_\_\_\_  
\_\_\_\_\_

Please list any and all vitamins you are currently taking

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Office Use

Date Received \_\_\_\_\_ MGMC Physician \_\_\_\_\_  
Date Accepted \_\_\_\_\_ Reason for Refusal \_\_\_\_\_