Dr [Physician Name]

[Clinic Address]   
[Clinic Hours]  
[Phone Number] [Phone Line Hours]

[Clinic Email Adress for patients, if applicable]

Thank you for your interest in joining [Clinic Name]. We’re happy to let you know that we’ve accepted your request to become a patient at our clinic. To complete your profile, we ask that you fill out this form so we can get to know you better and ensure your information is up to date prior to your first visit. The following policies are essential to the functioning of our clinic and enable us to provide prompt medical care for all patients.

**Office Policies**

**Appointment cancellation**

If you are unable to make it to your appointment, we ask you to advise us **at least 24 hours prior** to your scheduled appointment time. By doing this, we can provide access for another patient. All cancellations with less than 24h notification may be subject to an administrative fee.

**Appointment No Shows**

If you are unable to attend your appointment and have not notified our office 24 hours in advance, you will receive a warning letter. Should the same situation happen a second time, you will be billed for the cost of the missed appointment.

**Late arrivals**

If you arrive more than [X] minutes late to your scheduled appointment, you will be asked to reschedule. We understand that delays can happen; however, arriving late disrupts the schedule and impacts other patients.

**Initial Patient Visit**

At your first appointment, your provider will take time to get to know you and discuss important topics such as [I.e. your medical history, any current concerns, and your completed intake form]. [If applicable - We’ll also go over clinic policies and make sure all your questions are answered].  To help us make the most of your appointment, please arrive on time and bring the following:

* [Your Health Card (e.g., Medicare)]
* [A current list of medications]
* [Your completed intake form]

We typically schedule [X amount of time] for this initial visit. If additional concerns arise that require more time or follow-up, we may recommend a second visit to give each concern the attention it deserves.

**Patient Responsibility**

To ensure optimal follow-up of your care, we ask that you bring an up-to-date list of your medications to each appointment. It is also your responsibility to verify if he/she needs refills before your scheduled appointment.

**Costs**

Travel consultations (immunizations)– This service is not covered by Medicare; therefore, patients are responsible for the associated costs.

Filing various forms – Please consult our secretary for pricing. (i.e. Disability, Insurance, Driver’s Medical Forms)

**Respect Policy**  
Our clinic is committed to protecting our patients and our employees. Verbally or physically abusive behaviour will not be tolerated.

**AI Scribe Technology Notice and Consent**

As part of our commitment to providing efficient, high-quality care, our clinic may use secure AI scribe technology to help document your visit. This tool listens during your appointment and generates clinical notes to assist your health-care provider.

* The AI scribe does not retain or store audio.
* All data is handled in accordance with Canadian privacy and confidentiality laws.
* Your provider always reviews and finalizes the clinical notes.

I consent to the use of AI Scribe technology during my visits.

I do not consent to the use of AI Scribe technology during my visits.

If you have any questions, please speak with your care provider or a member of our team.

**Demographic Information**

Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M  F

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_ DOB (DD/MM/YYYY): \_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_ Mobile Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Notification Method:  Email  Text  Phone

Spouse Name (If applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Children Name(s) (If patient(s) of this practice): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Health Insurance**

Medicare Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry date: \_\_\_\_\_\_\_\_\_\_\_

Do you have public (i.e. New Brunswick Prescription Drug Program) or private health insurance? (i.e. Blue Cross, Sunlife, Manulife, Desjardins, etc.)  Yes  No

**Preferred Pharmacy**

What is your preferred pharmacy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Questionnaire**

Please select the problems that you currently have or have had in the past:

|  |  |
| --- | --- |
| **Heart** | **Lung** |
| Arrhythmia (abnormal heartbeat) | Asthma |
| Cardiovascular (infarction/heart attack) | COPD |
| Heart failure | Nodules/lung cancer |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Bladder/Kidney** | **Gland / Hormones** |
| Kidney problem | Diabetes |
| Bladder problem | Thyroid problem |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Skin** | **Bone/Muscle** |
| Eczema | Fractures/Sprains |
| Skin cancer | Herniated disk |
| Skin infection | Surgery |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Arthritis** | **Brain/Nerve** |
| Arthritis | Headache/Migraines |
| Osteoporosis | Stroke |
| Fibromyalgia | Neuropathy |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Metabolic** | **Psychological** |
| High blood pressure | Depression |
| Cholesterol | Anxiety |
| Obesity | Burnout |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Reproductive System** | **Intestine/Liver** |
| Menstrual problem/ Ovaries | Constipation |
| Inflammatory bowel disease (Crohn’s, Ulcerative colitis) |
| Pregnancy / Complications | Colon cancer |
| Liver problem |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Surgery in the abdomen |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Is there a family history of any of the following?** Diabetes, cancer, heart disease, liver disease, high bloodpressure, **s**troke or blood clots, dementia or Alzheimer’s disease, kidney disease, high cholesterol, joint or muscle problem (including arthritis), or other:  
Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Sibling:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any surgeries in the past?**  Yes  No  
If yes, please list type and date of all surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **Have you been hospitalized in the past?**  Yes  No

If yes, please list reason and date of all hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies (Drug or Non-Drug allergies):**  Yes  No  
If yes, please list all drug and non-drug allergies:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Are you currently taking any medication**  Yes  NoIf yes, please list all medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke?**   
 Current smoker (daily) ☐ Occasionally (non-daily) ☐ Former smoker  Non-smoker

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

**Do you drink alcohol?**  
 Daily Intake  Occasionally  Formerly Consumed  Do not consume

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

**Do you currently use any recreational drugs or illicit substances?**  Yes  No

What recreational drug or illicit substances do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you consume caffeine?**  
 Daily Intake  Occasionally  Formerly Consumed  Do not consume  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Do you exercise?**  
 Yes, I do regularly exercise  I do some exercise, but not as much as I should  No, I don’t exercise

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

*This document serves as confirmation that you are now under the care of [Physician's Name] at [Clinic/Practice Name]. This agreement is acknowledged and confirmed by the signatures of both the practitioner and the patient below.*

Patient signature: Date:   
  
We look forward to supporting your health & well-being.  
  
**Dr. [Add physician name]**