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Atlas Medical Clinic - Patient Intake Form

Registration for: ☐ **Dr. .l-Kl-Ǌ YK2ƨl-ǎűŜK**

PATIENT DEMOGRAPHICS

Last Name:	
First Name:	
Middle Name:	
Birthdate (mm-dd-yyyy):	
Health Card No:	
Sex:	☐ Male ☐ Female ☐ Other
☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr.	

CONTACT INFORMATION

Street Address:	
City:	
Province:	
Postal Code:	
Home Phone No:	
Alternate Phone No:	
E-mail Address:	

PREVIOUS FAMILY PHYSICIAN

Name:	
Phone No:	

EMERGENCY CONTACT

Name:	
Relationship to patient:	
Contact Phone No:	

PERMISSIONS

Do you give permission for Atlas Medical Clinic to leave you detailed voicemails in the event we are unable to reach you for clinic correspondence?

☐ Yes ☐ No

Do you give permission for Atlas Medical Clinic to correspond with family or friends on your behalf?

☐ Yes ☐ No

If yes, please name individual(s) we may contact:

May we add you to our email list for updates, schedule changes, and important news?

☐ Yes ☐ No

Occupation: _____

Do you have extended health benefits? ☐ Yes ☐ No

Do you have a power of attorney for medical decisions? ☐ Yes ☐ No

Please include his/her information: Name _____ Telephone No: _____

Allergies

If you have any allergies to medications, please list it below and include the reaction.

Medication	Reaction

Medical Conditions

Please list current and past medical/mental health conditions and any surgeries you have undergone. Please include the name of your specialist if applicable. Please feel free to attach another page if more space is required.

Condition	Specialist

Family History

Are there any medical/mental health conditions that run in the family? Please list family members and condition if known.

Family Member	Condition

Medications

Please list all medications (prescribed, over-the-counter, supplements/vitamins). Please list the reason you are taking these medications. Please feel free to attach another page if more space is required.

Medication	Reason (if known)

Preventative Care

Please attach a copy of your immunizations record if available. Please fill out any section that applies to you.

Test	Date of Last Test	Result (if known)
Pap smear (females)		
Mammogram (females)		
Colonoscopy		
Fecal occult blood test		
Bone mineral density		
Pneumovax		
Tetanus vaccine		
Herpes Zoster Vaccine		

Thank you for completing this form. Your information will be treated as confidential. Please feel free to include any additional information or comments below.