New Patient Intake Form

Georgina Nurse Practitioner-Led Clinic

Fillable PDF — type directly into the fields

PATIENT INFORMATION

LAST NAME | FIRST NAME | PREFERRED NAME

DATE OF BIRTH (YYYY-MM-DD) | SEX ASSIGNED AT BIRTH | PRONOUNS | GENDER IDENTITY (OPTIONAL)

HOME ADDRESS

CITY | PROVINCE | POSTAL CODE

MOBILE PHONE | ALTERNATE PHONE | EMAIL ADDRESS

PREFERRED LANGUAGE | HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT

FULL NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER

OHIP INFORMATION

OHIP NUMBER | VERSION CODE | OHIP EXPIRY (IF APPLICABLE)

CURRENT PROVIDER (FAMILY MD/NP, IF ANY)

MEDICAL HISTORY

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Asthma

☐ Cancer ☐ Seizure Disorder ☐ Thyroid Disease ☐ None of the Above

CURRENT MEDICATIONS (NAME & DOSAGE) *(if you're on multiple medications, please get a list from your pharmacy)*

KNOWN ALLERGIES (MEDICATIONS, FOOD, OTHER)

PAST SURGERIES / HOSPITALIZATIONS

PRIVACY & CONSENT (PHIPA)

I consent to treatment at GNPLC and to the collection, use, and disclosure of my personal health information by clinic staff as permitted under Ontario's Personal Health Information Protection Act (PHIPA).

☐ I consent to the above and confirm the information provided is accurate.

PATIENT / GUARDIAN SIGNATURE (TYPE FULL NAME) | DATE