Family Physician New Patient Intake Form

1. Personal Information

- Last Name :   First name :   (as per care card)

- Date of Birth (DD/MM/YYYY): _____ / _____ / _____

- Gender Identity: ☐ Male ☐ Female ☐ Prefer not to say

- PHN (Personal Health Number): _____

- Health Insurance Province (if not BC): _____

2. Contact Information

- Home Address: _____
  City: _____ Province: _____ Postal Code: _____

- Phone (Primary): _____ ☐ Mobile ☐ Home

- Alternate Phone: _____ ☐ Mobile ☐ Home

- Email: _____

- Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

3. Emergency Contact

- Name: _____

- Relationship: _____

- Phone Number: _____

4. Family Doctor & Previous Providers

- Have you had a family doctor in the past 2 years? ☐ Yes ☐ No

- If yes, Name & Location: _____

- Do you authorize us to request your medical records? ☐ Yes ☐ No
  Signature for release: _____ Date: _____

5. Medical History (brief summary)

- Do you have any chronic conditions (e.g., diabetes, hypertension)?
  ☐ Yes ☐ No – If yes, please list: _____

- Current medications: _____

- Allergies: _____

- Surgeries/Hospitalizations: _____

- Mental Health Concerns: _____

6. Social History (optional)

- Smoking: ☐ Current ☐ Past ☐ Never

- Alcohol Use: ☐ Yes ☐ No

- Drug Use (recreational): ☐ Yes ☐ No – If yes, explain: _____

- Do you have any cultural or language needs we should be aware of?

7. Consent and Privacy

- I understand this clinic may contact me regarding appointments, lab results, and referrals.

- I consent to the collection and use of my personal information for my medical care, in accordance with PIPA (Personal Information Protection Act).

- I consent to email communication for simple matters like clinic related matters,lab/investigation requisitions, appointment notices etc

Signature: _____ Date: _____ / _____ / _____

8. Preferred Pharmacy

- Pharmacy Name: _____

- Address: _____

- Phone # : _____ Fax : _____

9. Additional Notes (Optional: for administrative or physician use)

10.Signature and date