DRFMC
DAWSON ROAD FAMILY MEDICAL CLINIC

Patient Information Sheet

Preferred Name _____ Date of Birth _____

Legal Name on Health Card _____

Gender / How do you identify? _____

Preferred Pronouns: _____

Health Card #_____**Version Code**_____

Address_____**City**_____

Postal Code_____**Home Telephone**_____
Ok to leave a message? Y N

Cell Phone_____**Email Address**_____
Ok to leave a message? Y N Ok to email you? Y N

Name of last family physician?_____

Current Medications (list both prescription and over-the-counter, list the name of the medication, dosage and how often you take it) _____

_____

Drug/ Environmental Allergies_____

_____

Current Illnesses and past surgeries (include year of diagnosis or surgery)_____

_____

Additional Information that is important to your health care _____

_____

Signature_____**Date**_____

Please note that information herein will be shared amongst all Physicians and Nurse Practitioners who are accepting patients. At present we have a limited ability to take on new patients but this status fluctuates from week to week and we will contact if we are able to accommodate you/ your family. Please do not contact our office regarding this- if you have not heard from us with 3 months it means we are not accepting new patients and this form will be destroyed in keeping with the Personal Health Information Protection Act. All personal information is kept confidential.