EGLINTON HEALTH CARE CENTRE (416)438-6633

NEW PATIENT INTAKE FORM

Please Help Us by filling this form to know about you

Last Name_____ **First Name** _____

Date of Birth (YYYY-mm-dd)_____-_____-_____ **Sex M F Date:** _____

Address Apt#_____ **Street**_____ **City** _____ **Postal Code**_____

Phone # Home_____ Cell_____ Work _____

Email: _____

Health Card Number_____**Version Code**_____

Emergency Contact Person Last Name_____ First Name_____

Relationship_____ **Phone Number**_____

Are you allergic to any medication/Food Product? Y N

If yes please mention the name(s):_____

ARE YOU ON ANY NARCOTICS? Y N

Do you take any Medication Regularly? Y N

If yes please mention the Name:

1. _____
2. _____
3. _____
4. _____

Do You Have Any Medical Condition(s) Y N

If Yes Please Mention

1. **Diabetic Y N**
2. **Hypertension Y N**
3. **Asthma Y N**
4. **High Cholesterol Y N**
5. **Thyroid Y N**
6. **Other**_____

Have You Had any Surgery? Y N

If Yes Please Mention the Name and Date/Month/Year:

How did you get to know about us: Online/Friends & Family/ Flyers/ Newspaper/ Others

Do you have a Family Doctor: Y N

Family Dr's Last Name_____ **First Name:** _____