



Ear Falls Community Health Centre/ Family Health Team Intake Form

Please complete the information below to the best of your knowledge as applicable. Information provided will help us provide quality care and starts the new patient intake process. Completing this intake form does NOT mean you are rostered. Before an Intake appointment with a nurse is booked you MUST register for Health Care Connect online at: www.ontario.ca/healthcareconnect or call 811 24 hours a day, 7 days a week.

Legal Name: _____

Preferred Name: _____

Date of Birth: ____/____/____ (Day /Month /Year)

Sex: Gender Neutral Female Male Marital Status: _____

Ontario Health Card No. _____ Version Code: ____ Expiry date: _____

Address: _____

Street Number, Street Name, Unit/Apt. Number

City, Province, Postal Code

Home Number: (____) _____ - _____ Preferred Leave a message Yes No

Cell Number: (____) _____ - _____ Preferred Leave a message Yes No

Do you give us consent to leave a message on your voicemail about your:

Appointment Information (reminders, date, time) Yes No

Personal Health Information (e.g. test results, preventative care reminders) Yes No

Email: _____

Current Workplace/Job: _____

Emergency Contact Name: _____

Phone Number :(____) _____ - _____ Relationship: _____

Do you give us consent to communicate with this person about your:

Appointment Information Leave a message Yes No

Personal Health Information (e.g. test results) Leave a message Yes No

Do you have a substitute decision maker/legal guardian? No Yes.

If so, in what capacity? _____

Substitute decision maker/ legal guardian Name: _____

SDM/legal guardian Phone Number :(____) _____ - _____

I will contact the Ear Falls Community Health Centre/Family Health Team if any of the above information changes. Signature: _____ Date: _____



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Past Medical History:

Where have you been going for health care? _____

Walk-in clinic Community Health Centre Emergency/hospital Other _____

Past health care provider information:

Name: _____

Address: _____

Phone Number: (____) _____ - _____

What pharmacy do you use? _____

Medication Allergy: _____ Reaction: _____

Medication Allergy: _____ Reaction: _____

Non-medication Allergy: _____ Reaction: _____

Do you carry an Epi-Pen (circle option)? YES NO

Your past serious conditions, illnesses, injuries and/or hospitalizations & dates:

Condition/illness/hospitalization/ surgery:	Dates:
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Family Health History:

Has a close relative (parent, grandparent, sibling) had any of the following:

Cancer

Diabetes/Thyroid Issues

High Blood Pressure

Kidney Problems

Heart Problems/Stroke

High Cholesterol

Mental Health Diagnoses

Epilepsy/Seizures

Lung Problems/ Asthma

Current Medical History:

Current List of Medication(s)/ Vitamin(s)/ Over-the-counter Medication(s):



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Medication	Dosage and Frequency	Prescribed by

Do you use any of the following, how often, and in what form (as applicable):

Alcohol	
Nicotine	
Caffeine	
Marijuana	
Recreational/ Street Drugs	

Please list your current health concerns, in order of importance to you:

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

Is there anything else you feel may be important for us to know?

I consent to having occasional Virtual appointments (telephone appointments) and understand that the virtual appointment will NOT be recorded by either party and will be a private visit. Details of the appointment will be recorded in my chart. I understand a virtual appointment is not appropriate for an emergency. I understand that I may be asked to schedule an in-person appointment depending on the course of action needed for the Health Care Professional to provide quality care.

Signature: _____ Date: _____