PATIENT REGISTRATION / PORT DOVER DOCTOR'S OFFICE.

Please mail or fax to:	Dr Hadi, Port Dover Doctor's Office, 697 Highway 6, Unit 3, Port Dover, ON N0A 1N2. Fax number 519-583-0010

For non-medical information, please fill only the information you wish to have entered into your chart.
For medical information, please fill out a complete list of your current medications, past medical history, and current active medical issues.

DEMOGRAPHIC INFORMATION			
☐	Surname	Given Name(s)	
☐	Address:		
☐	City:	Province: ON	Postal Code:
☐	Phone Home:	Cell:	Work:

☐	OHIP card number:	Version Code

☐	Occupation:	Private insurance health plan: yes / no
☐	Email address (provide if you wish to be entered into chart):	
☐	Date of Birth / /	

☐	Emergency Next-of-Kin:	Relationship to you:	Phone number:

FAMILY MEMBERS UNDER THE AGE OF 16 WHOM YOU WISH TO REGISTER AT THE SAME TIME			
☐	Name	DOB	Health Card No.
☐	Name	DOB	Health Card No.
☐	Name	DOB	Health Card No.

PATIENT REGISTRATION HEALTH QUESTIONAIRE

The information you provide will be entered into your electronic medical record. We do not exclude anyone based on their health information

☐	Name of your last family doctor:	When last seen:
☐	Number of visits to the Emergency department in the past 6 months:	
☐	How would you describe your overall health ?	excellent / good / fair / poor
☐	Does your state of health limit your daily activiites in any way?	yes / no

Have you had the the following procedures?					
		Yes	No	Date (year)
☐	Pap test			
☐	Partial hysterctomy			
☐	Total hysterectomy			
☐	Mammogram			
☐	Colonoscopy			
☐	Colon Cancer Check			
☐	Bone Density Test			

Please list medical condtions and medications you are using		
	Your Medical Conditions	Your Medications
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		

Please list any surgeries		
	Surgery	Year of surgery
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		

Allergies

	Substance	Reaction
☐		
☐		
☐		
☐		

Recreational Substance Use

		Yes Past / Present	How much / How often	Never used
☐	Tobacco			
☐	Alcohol			
☐	Marijuana			
☐	Other (please list)			

Medical Conditions in your Family

☐	Diabtes			
☐	Stroke			
☐	Heart diease			
☐	Cancer (type)			
☐	Mental Health (type)			
☐				
☐				

Person filling out form (if other person, state relationship please)

Date completed:

All information on this form is treated confidentially and once reviewed shredded. Last updated: Monday, November 9, 2020