THREE BRANCHES MEDICAL

10 Bronte Street South, Suite #304
Milton, Ontario L9T 9M2
T: 289.851.7571

NEW PATIENT REGISTRATION FORM

Please return your completed form to Three Branches Medical at 10 Bronte Street South, Suite 304 or after hours, to Main & Bronte Pharmacy, Suite 102 on the main floor. Thank you.

Please Check Preference: ◯ *Male Physician* ◯ *Female Physician* ◯ *Specify:*_____

Personal Information

First Name	Middle Name	Last Name

Date of Birth (YYYY/MM/DD)	Gender	Preferred Name (optional)

Health Card Number & Version Code	Expiry Date (YYYY/MM/DD)

Home Address	Contact Phone Numbers/Email
_____ _____ _____	Mobile: _____ Home: _____ Email: _____

Marital Status	Children	Patient Occupation

Emergency Contact	Relation To You	Phone Number

Medical & Pharmacy

Previous Family Physician	Address/City	Phone & Fax Number

Preferred Pharmacy	Address/City	Phone & Fax Number

IMPORTANT: Clinic Policies

1. All patient information is kept strictly confidential. No medical /health information will be disclosed to any third party without consent.
2. A valid OHIP must be presented before each visit to receive medical care. For all medical services not covered by OHIP, payment is required at time of service.
3. 24 hour notice is required for all appointment cancellations. A cancellation fee will be charged for all missed appointments without 24 hour notice. *Thank you.*

Medical History

Medical Conditions - Please check or list all medical conditions and year of diagnosis. Conditions include but are not limited to the following:

- Addictions: alcohol/drugs/gambling
- Anemia
- Arthritis: rheumatoid/osteoarthritis/gout/ fibromyalgia/lupus
- Asthma/COPD/emphysema/chronic bronchitis & other lung conditions
- Blood clot (leg/lungs)
- Cancer and cancer treatment (surgery/radiation/chemotherapy)
- Depression/anxiety/bipolar, schrizophrenia
- Diabetes
- Diverticulitis/hemorrhoids
- Erectile dysfunction/enlarged prostate/sexually transmitted diseases
- Eye conditions (cataracts, glaucoma)
- Upper GI: heartburn/reflux/ulcers/gallstones
- Lower GI: Crohn's/colitis/IBS
- Gynecological (endometriosis/fibroids/cysts/abnormal PAP/STD)
- Headaches/migraines
- High blood pressure
- High cholesterol
- Heart disease (heart attack/heart failure/valve problems/angina
- Hypothyroid/hyperthyroid/nodules
- Joint, muscular problems
- Kidney stones/kidney failure
- Major childhood illness
- Neurological (seizures, MS, paralysis, brain injury)
- Osteoporosis/osteopenia
- Peripheral vascular disease
- Skin conditions: eczema,/psoriasis, skin cancers
- Stroke/TIA
- Urinary incontinence/prolaspsed bladder

_____

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Medications & Dosage* - Please list all current medications including over the counter medications and herbal remedies.	**Drug Allergies**
_____	_____
_____	_____
_____	_____

Please bring all your medications and immunization records to your first appointment.

Surgical History - Please list any past surgeries and the approximate year/date in which they were performed and the surgeon's name where possible. This includes childhood surgeries such as appendectomies and tonsillectomies.

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Family History - Please list family member's, age & year of diagnosis. Immediate family members would be parents, siblings, children/grandparents. Conditions include the following but are not limited to: blood clot in lungs or legs (DVT/PE), cancer (please list type), diabetes, heart disease/heart attack/heart surgery, mental illness (please list type), osteoporosis/broken hip, suicide and stroke.

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Preventative Care	**Social History**
Please indicate the last date (YYYY/MM/DD) of the following:	Smoking: [ ] Never smoked [ ] Previous smoker
PAP: _____	[ ] Current smoker No. cigarettes/day _____
Mammogram: _____	Alcohol history: No. of drinks/week _____
Colonoscopy/Stool Test: _____	Any recreational drugs: _____
Tetanus Vaccine: _____	Caffeine Intake: Cups of coffee/day _____
Bone Density Scan: _____	Exercise & physical activity: _____

Signature: _____ **Date:** _____

(Parent or Guardian Signature if patient under age 18)