**NEW PATIENT APPLICATION** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Card Number (10 digits): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ version code\_\_\_\_\_\_\_

Date of Birth (DD/MM/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE:\_\_\_\_\_\_\_\_\_

Gender: ☐ Male ☐Female

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Box # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mobile # (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact ☐ Phone ☐ Email

**Health information:** *How would you rate the following?*

General Health status: ☐GOOD ☐FAIR ☐POOR

Mental health status: ☐GOOD ☐FAIR ☐POOR

## **Have you ever had or been told you have: (check all that apply)**

☐Diabetes ☐Asthma ☐Bronchitis ☐COPD ☐Cancer

☐Stroke ☐Hypertension ☐Heart attack (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Thyroid disorder

☐Irregular Heart beat ☐High cholesterol ☐Hepatitis ☐HIV/AIDS ☐Arthritis

☐Sleep Apnea ☐Dementia ☐Inflammatory bowel disease ☐Chronic Pain

Other (please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:** ☐I have had surgery (Type and dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Do you smoke cigarettes:** ☐NO ☐YES (cig/day) \_\_\_\_\_\_\_ ☐I QUIT! (when)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐I would like to quit

**Alcohol or substance abuse:** ☐NO ☐YES

**For Women:** Last Pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Pregnant? ☐NO ☐YES # pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # children born \_\_\_\_\_\_\_\_\_\_\_

Last Colorectal Screening (FOBT kit or colonoscopy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **For Men:** Last Colorectal Screening (FOBT /FIT kit or colonoscopy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_

Last PSA test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Immunizations:**

Last Flu Shot: \_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumovax (65 & older or high risk): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles Vaccine (65 & older): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tetanus Booster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childhood vaccines ☐UP TO DATE ☐Requires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication List (please list all medications including creams, vitamins etc.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who has been providing your current/previous medical care?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Welcome to the Chapleau & District Family Health Team**

Please complete the following application in order to be waitlisted for an intake appointment for a family physician. We require separate applications for each member of your family.

Your health and wellbeing are very important to us and we will work hard to make sure you have care while you are awaiting acceptance with a family physician.

Applications will be ranked in order of medical need so it is ***very important*** that you fill in the application fully. If your condition changes while you are waiting for your first appointment, please call and let us know so that we can update your application.

**If you are in need of emergency care, please present to the nearest Emergency Department.**

**If you would like to be tested for Covid-19 please call the Covid-19 assessment Centre @ (705) 864-2568.**

**How to access care while waiting for a family physician:** While waiting for a physician you will have access to any of our health programs, our nursing staff and our resources. A full list of available services can be accessed on our website [**www.cdfht.org**](http://www.cdfht.org)**.**  We also provide a locum doctor and virtual Nurse Practitioner appointments on select days. Please call (705) 864-0210 to inquire about an appointment.

**Special note: Most appointments will continue to be virtual for health and safety reasons. If your condition requires a face to face assessment you will be booked for one. If after your virtual appointment the physician or nurse practitioner feels you should be assessed in person you will be contacted for an appointment. Masks must be worn in clinic at all times.**

By filling in this application you acknowledge that we may contact you:

1. To book an appointment with an accepting physician,
2. To offer you space in one of our many health programs,
3. To provide a follow up appointment to review bloodwork or medication review.

If you prefer to be contacted by email please provide your email address on the application.

Your privacy is important to us and we will never share your information without your consent.

Please contact us if you have any further questions or require more information.