Mapleview Medical Center

Patient Name: _____ Male / Female

Date of Birth: (mm/dd/yyyy): _____ Age: _____

Health Card Number: _____ Expiry Date: _____

Full Address: _____

Phone Number: _____ Alternate Phone Number: _____

Email: _____ Would you like clinic updates? Y or N

Do we have permission to release information to anyone other than yourself? Y or N

If yes, please provide:

Name: _____ and Phone Number: _____

Current Medical Concerns: (ie. High blood plressure, Asthma, Depression etc.)

_____

_____

_____

Past Medical History/Surgeries (ie. Heart attack, Tonsillectomy, Appendix removal etc.)

_____

_____

_____

Medication List: (Name, Dose, Frequency, or pharmacy printout)

_____

_____

_____

Allergies: _____

Do you smoke?: Y or N _____ Do you drink? Y or No _____

Family History: (ie: High blood pressure, diabetes, cancer etc.)

_____

_____

_____

(please see other side)

NARCOTICS

Our office maintains a STRICT narcotic policy in order to minimize the potential for misuse. Prior treatment and existing narcotic prescriptions do not guarantee that narcotics will be prescribed to you. **PLEASE KNOW THAT NARCOTICS WILL NOT BE PRESCRIBED AT THE MEET AND GREET APPOINTMENT**. Narcotic overuse (over 7 days) will require that all patients sign a narcotic use contract. Patients suspected of narcotic prescription misuse will be subject to possible termination of the patient-physician relationship.

PRESCRIPTION REFILLS

Our office **DOES NOT** refill prescriptions over fax or phone. It is the patients responsibility to book an appointment with their health care provider at least TWO WEEKS prior to running out of medications. The doctor will prescribe the amount that he or she feels you will need before you need to see them again in the office.

Please be advised we will not accept this application over e-mail.

By signing below, you acknowledge that you read and understand the declarations and have answered all questions truthfully.

_____

Patient/Parent or Guardian Signature

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