



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 pressure, 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.

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**Patient/Parent or Guardian Signature**

**Mapleview Medical Clinic  
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