the medical station

centred on care

Patient Intake Form

Welcome to The Medical Station! Please complete this form prior to your first appointment for review by your physician.

Date: ____________________

Patient Name: ____

Date of Birth (dd/mm/yy): __________________

Address: ____

Home Phone: _______________________________ **Cell Phone:** __________________________________
Work Phone: ___________________________

What is your preferred number? ☐ Home ☐ Cell ☐ Work

Can we leave a message? ☐ Yes ☐ No

Email: ____

Would you like to be added to our newsletter and mailing lists? ☐ Yes ☐ No

Health Card Number: ____

Expiry Date (dd/mm/yy): __________________________

Emergency Contact: ____

Relationship to you: ____________________________ **Phone Number:** _________________________

Before you meet with the doctor, is there anything else you would like to share with us?

____
____
____

Referred by: ____

How did you hear about us?

☐ Website	☐ Signs	☐ Walk-in	☐ Social Media
☐ Friend	☐ Organization/group	☐ Physicians	
☐ Referral	☐ Family	☐ Flyer/poster	

Disclaimer: I understand the information provided above is true. This information is confidential to The Medical Station physicians and staff.

Signature: ______________________________________ **Date**: _________________________________

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