Niagara Medical Group
Family Health Team

4421 Queen Street,
Niagara Falls, On L2E 2L2
(905) 356-2236

New Patient Information Package

Please find enclosed the necessary information we will need for you to complete **prior** to accepting you as a patient.

Please follow the instructions carefully. Print clearly and legibly. Incomplete forms will result in a slower process.

1) Please date and put your name on **ALL** pages. Forms will be processed in order in which they are received.

2) **A set of forms must be completed for each family member.**

3) Ensure your Health Card is Valid (check Expiry date), the number is correct and include the version code (2 letters at the end of the number).

4) Please be **Honest** on all Personal/Medical History.

5) List as many surgeries and medical history as you can recall (specific dates not necessary, an approximately year would be sufficient).

6) If you are currently taking any prescription medications **we will require a Pharmacy Print Out, (Must be submitted with this form).**

Niagara Medical Group adheres to a Strict Policy regarding NARCOTIC MEDICATIONS. No patient will be prescribed narcotic medications without previous medical investigation, documentation and only at the Doctor's discretion.

7) Immunization records required for all children under the age of 16 **please provide photocopy**. (If you do not have a record for your children, Public Health will be able to provide you with one.)

8) Transfer of records from other Physicians will be done only when necessary.

9) Return entire package as soon as possible. **We will call you when your paperwork has been processed and a Dr. has been assigned to you.**

Enclosed is information from the Ministry of Health, general information about our office and programs we offer. Please take time to review **and/or** visit our website.
Website: www.NiagaraMedicalGroup.com

Patients currently without a family Doctor or patients with a family Doctor outside the Niagara Region will be given priority.

Current processing time approx. 4 weeks
For all New Patient enquiries and appointments contact:
Katrina @ Ext # 243

Niagara Medical Group
Family Health Team

Dr. R. M. Guise, M.D.,F.C.F.P.
Dr. J. M. Morin, M.D.,C.C.F.P.
Dr. E. Wassif, M.D.,C.C.F.P.
Dr. E. Zufelt, M.D.,C.C.F.P.
Dr. R. Hogg, M.D.,C.C.F.P.
Dr. A. Brar, M.D.,C.C.F.P.
Dr. C. Russell, M.D.,C.C.F.P
Dr. K. Tenhoeve, M.D.,C.C.F.P.
Dr. J. Kho, M.D.,C.C.F.P.

4421 Queen Street
Queen Street Medical Building
Niagara Falls, ON L2E 2L2
Phone: (905) 356-2236
Fax: (905) 356-2568
www.niagaramedicalgroup.com

Regular Office Hours

Monday: 9:15 – 7:30
Tuesday – Thursday: 8:30 – 7:30
Friday: 8:30 – 12:30 and 2:00 – 6:30
Saturday: 9:00 – 12:30

Office Extensions

Appointments/Switch Board Ext# 0
Business Office Ext # 223
Workshop Registration Ext # 274
Program Secretary (Nutrition, Chiropody) Ext # 265
Prescriptions Ext # 276
Lab Ext # 252
New Patient Information Ext # 221
Referrals Ext # 227 or 305

Urgent Care Clinic (On Premises)

Monday – Thursday: 11 a.m.-12 and 2:00 – 7:30
Friday: 11 a.m. – 12 and 2:00 – 5:00
Saturday: 9-12:30 a.m.
Same Day Bookings, By Appointment Only (NO Walk-Ins) Care Provided by our Physicians and Nurse Practioners

Urgent Care problems are considered – Workplace Injuries, cough, cold, sore throat, ear and eye infections, rashes and minor acute problems, etc.... Please Note: In cases of severe shortness of breath, chest pain, and all fractures you should call 911 or go directly to your local Emergency Department

* *PLEASE NOTE: Due to Urgent Care Clinics being provided on promises, we ask that you* *
DO NOT USE Walk-In-Clinics. *The physicians of the group will be negated (required to pay) for the services you receive at Walk-In-Clinics. Also, the Walk-In-Clinics are not obligated to provide your physician with any information collected at your visit.*

Services Available to all Enrolled Patients (On Site)

Wellness and Prevention Program
Workshops on a variety of health-related issues
Collaborative Care Management
Mental Health Counseling
Chronic Disease Management
Laboratory and ECG Services
Diabetic Foot care
Healthy U Program
Psychiatric Services
Smoking Cessation Program
Nutrition/Dietician Services
Nurse Practioners

Affiliations with Community Agencies: such as Arthritis Society of Canada and Heart Niagara

Prescription Repeats and Renewals

If you require a repeat or renewal of your prescription, please have your pharmacy fax a request to our office and allow 24-48 hours, for our office to process.
It its recommended that each patient deal with one pharmacy, this is to provide more continuity and better health care.

Test Results

Due to the volume of test results the office will only notify you of abnormal results. If you do not hear from the office and wish to discuss your results you can book an appointment with you Doctor.

After Hours Service

When contacting our office after hours, you will be directed to either the answering service or the Telephone Health Advisory Service (THAS). A THAS Registered Nurse will triage your condition over the phone and direct you to the appropriate services at that time. Your Physician will be provided with a report of all telephone inquiries that are directed to THAS.

**** IF YOU MISS YOU INITIAL APPOINTMENT YOU WILL NOT BE ACCEPTED INTO THE PRACTICE*****

Niagara
Medical Group
Family Health Team

Date_____
day / month / year

New Patient Data Base (Adult)

Name_____ (as it appears on your Health Card)

Date of Birth _____/_____/_____ Age _____

Health Card # _____ Version Code_____

Expiry Date _____ Sex Assigned at Birth _____ Gender:_____

Address _____

City _____ Postal Code _____

Home Phone # _____ Work #_____ Cell # _____
(Include Area Code)

Emergency Contact and/or Next of Kin_____

Home Phone # _____ Work # _____ Cell # _____

In which language would you most prefer your care _____

Do you currently have a Family Dr ..... YES / NO

Previous Family Dr _____

Address _____

City _____ Phone # _____

Are you currently under the care of any Dr ..... YES / NO

When was the last time you were seen by a Dr? _____

When did you last have a physical? _____

Have you had any tests/procedures done in the past 6-12 months ..... YES / NO
(e.g.: Blood Work, X-Rays, and Ultrasound)

If yes, where did you have the test(s) done? _____

Do you take medication on a regular basis ..... YES/NO

Have you ever had a colonoscopy..... YES/NO

If yes, when _____

Personal History / Demographics

Which of the following best represents your racial or ethnic heritage?(Circle all that apply)

White	Black/African American	West Asian/Arab	Latin American/Hispanic	South Asian
Indigenous/First Nations	Metis	Inuit	East/Southeastern Asian	Other:

Marital Status: (circle) Single Married Widowed Divorced Separated Common-Law

Who do you live with: (circle) Self Spouse Children Parents Grandparents

Occupation: _____ Full Time / Part Time

Are you a Student ..... YES / NO

School _____ Grade _____

Smoker ..... YES / NO

Please indicate: (circle) Cigarettes / Cigars / Pipe

If yes: # per day _____ How long have you been a smoker _____

Have you ever tried to quit smoking ..... YES / NO

Alcohol ..... YES / NO

Would you normally drink: (circle) Beer / Wine / Liquor

If yes: # of drinks _____ per week / per month

Street Drugs ..... YES / NO

Please indicate drug and frequency _____

When was your last **Eye Exam** _____

Do you wear glasses / contacts / or had laser corrective surgery ..... YES / NO

Do you visit the dentist regularly ..... YES / NO, How often _____

Do you wear dentures: ..... YES / NO

Are you an **Organ Donor** ..... YES / NO

Do you follow any **Special Diet** ..... YES / NO

_____

(e.g.: vegetarian, low salt, high fibre, or diabetic)

Do you exercise on a regular basis ..... YES / NO
If yes, what kind of exercise do you do (e.g.: walking, cardio)

_____

Frequency _____ Duration _____
(e.g.: 3 times per week for 30 minutes)

Past Medical and Surgical History
Please complete this section as accurately as possible
if more space is needed, use separate sheet of paper.

Have you ever been a victim of Physical or Sexual Abuse ..... YES / NO

Have you ever had surgery ..... YES / NO (if yes, please list)

Have you ever had any broken bones ..... YES / NO (if yes, please list)

Have you ever been **Hospitalized** for any other reason ..... YES / NO (if yes, please list)
(Not including surgery or maternity)

Please list current **Medical Conditions**. _____
(e.g. : diabetes, high blood pressure, arthritis)

Please list all **over the counter medications** you are currently taking
(Include vitamins/herbal)

Prescription Medications:

Have you taken **ANY** prescription medication in the past 6 months ..... YES / NO

Are you currently taking **ANY** prescription medication ..... YES / NO

What Pharmacy do you deal with (please give location) _____

1) **Provide a current Pharmacy print out of medications; please have your Pharmacy include dosage and frequency.**
   (MUST BE SUBMITTED WITH THIS FORM)

2) **Please bring all medications to your first appointment.**

Are you currently under the care of any **other Health Care Professional(s)** ... YES / NO
(Specialist, Physiotherapist, Chiropractor, Mental Health, Addictions Counselor, Weight Loss Centre, Naturopath, etc.)
If yes, please list _____

_____

_____

_____

Female Health

At what age did your menstrual period start _____

At what age did your menstrual period stop _____

# of Pregnancies _____ # of Live Births _____

When did you last have a Pap Smear / Pelvic Exam _____

When did you last have a breast exam (done by a Dr.) _____

Last Menstrual Period _____

Do you do a monthly self breast exam ..... YES / NO

Do you use Birth Control ..... YES / NO

Type of Birth Control _____

Have you had the Gardisil Vaccination ..... YES / NO

Have you ever had a Mammogram or Breast Ultrasound ..... YES / NO
If yes, when _____

Have you ever had a Bone Density..... YES / NO
If yes, when _____

Male Health

Have you ever had a testicular exam ..... YES / NO

Have you ever had a digital/rectal exam ..... YES / NO
If yes, when _____

Have you ever had a PSA test (blood test for prostate cancer)..... YES / NO
If yes, when _____

Immunizations:
A copy of your Immunization Record MUST be provided for all children less than 16 years of age.

When did you last have a Tetanus Shot _____ / Unknown

Do you get the Flu Shot yearly ..... YES / NO

Have you ever had the Pneumonia Shot ..... YES / NO
If yes, when _____

Please tell us about other vaccinations you have had (e.g. : Gardisil, Hepatitis, Travel)

Allergies

Do you have any allergies ..... YES / NO
(If yes, please list and tell us about your reactions)

Do you carry and EPI-Pen ..... YES / NO

Family History: (Mother/Father/Aunts/Uncles/Brothers/Sisters/Grandparents)

Diabetes _____

High Blood Pressure _____

Heart Disease _____

Asthma _____

Glaucoma _____

Cancer _____

Depression _____

Other _____

Please feel free to use this space to tell us anything that may not have been covered, or any **current problems or concerns** you would like to discuss with the Doctor in the near future.

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Transfer Form

Consent to Obtain Records from Previous Physician

I hereby authorize my previous physician:

_____

(Name of Physician) (Street Address)

_____

(City) (Prov.) (Postal Code) (Telephone)

To disclose the following personal health information:

my entire chart or

Specific medical information regarding:

_____

To my new physician:

Dr. R. Guise	Dr. E. Zufelt	Dr. A. Brar
Dr. J. Morin	Dr. R. Hogg	Dr. K. Tenhoeve
Dr. E. Wassif	Dr. C. Russell	Dr. J. Kho

Patient's Name:_____ DOB:_____

Address:_____ City:_____

Postal Code:_____ Phone:_____

I understand that this personal health information is to be used ONLY by the recipient for the purposes of providing primary care. I hereby waive any and all claims against Niagara Health Services and my Physician, as indicated above, in connection with the disclosure of this personal health information. **I also understand my previous physician MAY charge me for the transfer of my records to my new physician.**

Witness: _____ Signed By: _____

(Patient or Substitute Decision Maker)

Date: _____

_____

(Relationship to the Patient)

Ontario Ministry of Health

Primary Health Care New Patient Declaration

Do not mail this form to the ministry. This form must remain in the physician's office for audit purposes.

Please complete this form if you are a new patient of a primary care physician and have signed a Patient Enrolment and Consent to Release Personal Health Information form. If you are signing on behalf of a child or dependent adult, and have completed a Patient Enrolment and Consent to Release Personal Health Information form on their behalf, complete the applicable sections below.

Declaration

I am signing on behalf of *(check the applicable boxes)*

- ☐ myself *(complete sections A and C)*
- ☐ the children listed below of whom I am the parent or guardian *(complete sections B and C)*
- ☐ the dependent adult (s) listed below for whom I have a power of attorney for personal care *(complete sections B and C)*

I hereby declare that the patient(s) named below does/do not have a family physician due to one or more of the following circumstances: *(check applicable boxes)*

- ☐ The patient's family physician has moved to another community.
- ☐ The patient has moved to another community.
- ☐ The patient's physician is no longer available due to illness/death/retirement.
- ☐ The patient's physician is no longer available due to change of practice type.
- ☐ Up until now the patient has not had, or felt the need for a family physician.

Section A: Patient Information

First Name	Last Name	Health Number

Section B: Children and Dependent Adults

	First Name	Last Name	Health Number
1.			
2.			

For additional children / dependent adults, please complete another New Patient Declaration form.

Section C: Signature and Date

Signature	Date yyyy/mm/dd

Section D: Physician Signature and Date

I declare that the above patient is not presently a patient of mine or, to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable). I also declare that no child listed (if any) is a newborn of any existing enrolled or non-enrolled patient of mine, or to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable).

I agree to accept the above-noted patient(s) into my practice and to provide ongoing health care to the patient(s) from the date of this document. I will keep this document available on file in my primary office location and will provide copies to the Ministry of Health as required for verification purposes.

Physician Last Name *(print)*	First Name *(print)*

Physician Signature	Date yyyy/mm/dd

Ontario Ministry of Health Ministère de la Santé

Patient Enrolment and Consent to Release Personal Health Information

You are being asked to enrol with a primary health care **Group**. A primary health care group is a group of family doctors and other health care providers who are working together to give you and your family continued access to quality primary care services.

Enrolling with a primary health care group is your choice. If you choose to enrol, please fill out this form **using a black or blue ball point pen** as follows:

- To enrol **yourself** . . . . . *complete* ***Sections 1 & 3***
- To enrol **yourself** and up to **two** children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care . . . . . *complete* ***Sections 1, 2 & 3***
- To enrol children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care but **not** yourself . . . . . *complete* ***Sections 2 & 3***
- To enrol **more than two** children under 16 years of age or dependent adults for whom you are a parent, legal guardian or attorney for personal care . . . . . *complete* ***Sections 2 & 3*** *on a separate form*

Note: If the mailing address includes a post office box (P.O. Box), rural route (R.R.), or general delivery, you must also complete the residence address.

If your primary health care group is not already identified or is incorrectly identified in Section 4, please print the name of the Group inside the box in Section 4.

Your Group will acknowledge your enrolment form in Section 4 and will provide you with a copy for your records.

For questions about enrolment and consent, filling out this form or to receive additional forms, please call INFOline at 1 888 218–9929 (TTY 1 800 387–5559).

Instructions:

1. Remove this instruction page.
2. Complete the form as instructed above.
3. Read the back of the form and Section 3 before signing and dating it.
4. Return all copies of the completed form to your Group or in the envelope provided.

PG04041
[redacted]
NIAGARA MEDICAL GROUP FHO

(Un formulaire bilingue est également disponible. Pour en recevoir un exemplaire, composez le 1 888 218-9929)

4391-80 (2012/04)

Ontario Ministry of Health

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218–9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 - I want to enrol myself with the Primary Health Care Group identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Mailing Address
Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

Section 2 - I want to enrol my child(ren) under 16 and/or dependent adult(s) with the Group identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ or ☐ same as Section 1
Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Section 1
Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ or ☐ same as Section 1
Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Section 1
Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

Section 3 - Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor, Group and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 - Primary Health Care Group Information

PG04041
[redacted]
NIAGARA MEDICAL GROUP FHO

BILLING NO. 066431 GROUP NO. BAAQ

(Include Billing no. and Group no.)

Signature on behalf of Group
X

Date *(yyyy/mm/dd)*

Office use Only *(print)*

Billing Number

PHYSICIAN COPY