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.

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. C. Russell, M.D.,C.C.F.P.
Dr. A. Brar, 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
Chiropody
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

Child Patient Data Base

Name _____ Date of Birth _____
Health Card # _____ Version Code _____ Expiry Date _____
Biological Gender _____

To which gender identity do you most identify: **(Circle)**

Male	Female	Trans M-F	Trans F-M	Intersex	Prefer not to say
Other:					

Address _____
City _____
Home Phone # _____

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:**

In which language would you most prefer your care? _____
Do you currently have a Family Doctor Yes No
Previous Family Doctor _____
Address _____
City _____
Are you currently under the care of any Doctor? Yes No
When was the last time you saw a Doctor? _____
When did you last have a physical? _____
Have you had any tests/procedures done in the past 6-12 months?
(e.g.: blood work, x-rays, ultrasound)
Yes No
Do you take any Medication on a regular basis? Yes No

Personal History

Who do you live with: Self Parents Grandparents (Circle all that apply)
Are you a student? Yes No
Have you had Laser Eye Surgery? Yes No
When was your last Eye Exam? _____
Do you visit the Dentist regularly? Yes No
How often? _____
Are you an organ donor? Yes No
Do you follow any special diet? Yes No
(e.g.: vegetarian, low salt, high fibre, diabetic) _____
Do you exercise? Yes No
If yes what kind of exercise do you do (e.g. Walking, Cardio) _____
Frequency and Duration (e.g.: 3 times per week for 30 minutes) _____
Have you ever been a victim of: Physical Abuse _____ Sexual Abuse _____

Allergies

Do you have any allergies? Yes No

If yes please list and tell us about your reaction_____

Niagara Medical Group
Family Health Team

Past Medical and Surgical History

Have you ever had Surgery? Yes No

Surgery	Year	Doctor	Hospital

Have you ever had any broken bones? Yes No
(If Yes please list and include year)

Bone	Year

Have you ever been hospitalized for any other reason? Yes No
Please list all current/ongoing Medical Conditions

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

Prescription Medications to ensure accuracy

1. Provide a current pharmacy print out
2. Sign a consent to release information so we can obtain a copy from your pharmacy on your behalf

What Pharmacy do you deal with (Please provide location) _____

Immunizations (Please Provide Immunization Record if you have one)

Do you get the flu shot yearly Yes No
Please tell us about other vaccinations you have ad (e.g.: Gardisil, Hepatitis, or Travel)

Family History	Mother	Father	Aunts	Uncles	Brothers	Sisters	Grandparents
Diabetes							
High Blood Pressure							
Heart Disease							
Asthma							
Glaucoma							
Cancer(Specify)							
Depression/Anxiety							
Other(Specify)							

Female History

Last Menstrual Period _____
Do you use Birth Control? Yes No
If yes, what do you use? _____
Have you had the Gardisil Vaccination? Yes No

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

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

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 &***
- 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 &***
- 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 &***
- 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 for*

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)

Ontario Ministry of Health

Patient Enrolment and Consent to Release Personal Health Information

Microfilm use only

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 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 Delive

City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

or ☐ same as Mailing Address

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 ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Deliver

or ☐ same as Section 1

City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

or ☐ same as Section 1

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 ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Deliver

or ☐ same as Section 1

City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

or ☐ same as Section 1

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
First name | Last 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

Patient Enrolment and Consent to Release Personal Health Information

Patient Commitment

I agree to contact my primary health care group (Group), or the designated Telephone Health Advisory Service, when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my Group or the ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this Group and enrol with another primary health care group or another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change the Group or family doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm his or her enrolment/consent with the Group.

Consent to Release Personal Health Information

I understand that my Group will be able to offer better medical care if I permit my Group and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my Group and the ministry to exchange the information in this form related to my enrolment.

I agree that my Group and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following specific information to my Group:

- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a primary health care group or a family doctor outside my Group

I agree to allow my Group and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, health number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:

- My enrolment with my Group ends or
- I cancel my consent by writing or telephoning the ministry (see box below).

The ministry will inform my Group when the consent is no longer valid. However, I understand that the information already released to my Group will remain in my medical file.

Cancellation Conditions

Enrolment with my Group and my consent to release personal health information ***will end*** when:

a) I cancel my enrolment by writing my Group or by writing or telephoning the ministry *(see box below)*;
b) I no longer qualify for health care services under the *Health Insurance Act (Ontario)*.
c) the Group no longer exists,
d) I enrol with another Group or family doctor; or
e) the ministry grants me an extended absence.

My enrolment with my Group and my consent to release personal health information ***may end*** when:

a) I consistently fail to meet the obligations to which I agreed in the Patient Commitment *(above)*.
b) my family doctor leaves this Group. If this happens, I may be able to enrol with my family doctor in another Group or I may choose to continue my enrolment with this Group;
c) my family doctor chooses to discontinue acting as my family doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines;
d) I become a resident of a long-term care facility;
e) I am imprisoned in a provincial or federal correctional institution; or
f) I move outside the geographic area where the Group regularly provides services.

Contact Information:

Ministry of Health
P.O. Box 48, Station Main
Kingston ON K7L 9Z9

Call: INFOline 1 888 218-9929
TTY 1 800 387-5559

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

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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)