

Six Nations Family Health Team

Dr. J. Zacks, M.D.
Dr. R. Renn, M.D.
Dr. M. Shigwaja, M.D.
Dr. G. Teitelbaum, M.D.
Dr. E. Sault, M.D.
Dr. M. Bomberry, M.D.



New Patient Information Package

Please find enclosed the necessary information we will need for you to complete PRIOR to adding you to our waitlist/accepting you as a patient

Please follow the instructions carefully. Print clearly and legibly, incomplete forms will result in a delayed process.

******Six Nations Family Health Team currently has a waitlist in place, we cannot currently guarantee or provide an estimate as to the length of time you will be waiting to be booked for an intake appointment with one of our medical clinicians*******

- 1) Please date and put your name on ALL pages. Forms will be processed in order of receipt.
- 2) **A set of forms must be completed for each family member.**
- 3) Ensure your health care 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 are not necessary-approximate years will suffice)
- 6) If you are currently taking any prescription medication- **we will require a pharmacy printout from all your pharmacies (Must be submitted with this form)**

Six Nations Family Health Team 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 are required for all children under the age of 16. Please provide a photocopy. (If you do not have one, please contact public health to obtain)
- 8) Transfer of records from other Physicians will be done only when necessary.
- 9) Return the entire package as soon as possible. *We will call you when your paperwork has been processed to notify you that your name has been added to the waitlist. You will then be called a second time to notify you when your name has been removed from the waitlist and a doctor has been assigned to you- at this time your first Intake Appointment will be booked.*
- 10) **If there has been no communication within 2 months, please contact Clinic Office Manager for further information.**

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New Patient Intake Form

Full Name _____

Biological Gender _____

Which Gender do you most identify? (Circle One)

Male Female Two Spirit Trans M-F Trans F-M Intersex Prefer not to say

D.O.B _____ Email address: _____

Address _____ Phone # _____

_____ Alternate Contact _____

Health Card# _____ EXP _____ Next of Kin _____

Current Dr? Yes ___ No ___ If Yes, Who? _____ Where? _____

Traditional Healer? Yes ___ No ___ Interested ___ If yes, Who? _____

May we leave messages about cancellations/closures, etc. on your phone? Yes ___ No ___

May we leave confidential messages about results on your phone? Yes ___ No ___

Employment status: Retired ___ Employed ___ Self-Employed ___ Unemployed ___ Student ___

Marital Status: Single ___ Married/common law ___ Widowed ___ Separated/Divorced ___

Racial/Ethnic Heritage? _____

Do you Smoke or use Tobacco? Yes ___ No ___ Packs per day? ___ How long? ___

If no, did you ever smoke? Yes ___ when did you quit? _____

Do you drink Alcohol? Yes ___ No ___

If yes, How many per week? ___ When was the last time you saw a Doctor? _____

When did you last have a physical? _____ Eye exam? _____ Dental exam? _____

Have you had any tests or procedures done in the past 6-12 months?(bloodwork, Xrays, ultrasounds etc)

Have you visited an Emergency room in the past 0-12 months? Yes ___ No ___ If yes, how many times have you visited? _____ Were you admitted to a hospital unit other than emergency room overnight?

Yes ___ No ___ If yes, how many times have you been admitted to a hospital unit overnight in the last 12 months? _____

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Do you follow a special diet? Yes___No___(eg.Vegetarian, low salt, high fibre, diabetic, keto etc)

If yes, what do you follow? _____

Do you exercise? Yes___No___If yes: Frequency_____Duration_____

Please list any allergies you may have and your reaction:(alternatively-attach list)

Please list any surgeries you have had in the past: (alternatively-attach list)

<u>Surgery</u>	<u>Year</u>	<u>Doctor</u>	<u>Hospital</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Health Medical History *circle all that apply*

Asthma	Hypertension	Arthritis	Heart disease	Stroke
Anxiety	Bipolar Disorder	Addiction	Depression	Kidney Disease
Emphysema	COPD	Glaucoma	Heart failure	Osteoarthritis
Diabetes	Obesity	High Cholesterol	Fibromyalgia	Parkinson's
Dementia	Lupus	Hypothyroid	Hyperthyroid	Lyme's disease
Cataracts	Vitamin Deficiency	Atrial Fibrillation	Rheumatoid Arthritis	
Irritable Bowel Syndrome		Coronary Artery Disease		

Have you had Covid? Yes___Date_____No___

Do you have a Genetic Condition
(specify)_____

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Cancer (specify
when/where/type/treatment) _____

OTHER Prior medical conditions not listed (specify)

Female History

Last Menstrual Period _____

Infertility concerns? Yes ___ No ___

Are you currently pregnant? Yes ___ Due Date: _____ No ___

History of (circle appropriate)

Endometriosis Polycystic Ovarian Syndrome Miscarriages
Heavy bleeding Hormone imbalance Fibroids/cysts
Extreme PMS symptoms

Menopause – if yes, have you had bleeding since menopause? _____

Last Mammogram? _____

Do you use birth control? Yes ___ No ___ If yes, what do you use? _____

Have you had the Gardasil Vaccination? Yes ___ No ___

When was your last pap/cervical cancer screening exam?

Was it normal or abnormal? _____

Any previous cervical/uterine biopsies or testing due to abnormal pap results?

Other concerns not mentioned

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For all patients to complete:

Traditional medicine plans/treatments currently following:-

Prescription Medications

*****To ensure accuracy: Please provide a current pharmacy print out – forms sent back without a list will not be accepted to the waitlist**

Current Pharmacy _____ Phone _____

Medications/Vitamins/Supplements: Please attach a medication list printed out from your pharmacy

List Vitamins/Supplements currently
taking: _____

Vaccination History: *Circle appropriate and provide year obtained- alternatively, provide your immunization records*

TYPE	MONTH/YEAR
Influenza/Flu Vaccine	
Pevnar 13, Pneumovax	
Zostavax (shingles)	
COVID Astra Zeneca, Moderna, Johnson, Pfizer or other: _____	Doses: 1,2,3,4

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Preventative Care:

<u>Question:</u>	<u>Yes or No</u>	<u>Approx. date/year</u>
Have you had a Bone Density Test?		
Have you had a Prostate exam?		
Have you had a Colonoscopy?		
Have you used a take home Colon Cancer stool sample test?		

Physicians: Please circle which physician you would prefer to see.

Dr. Ryan Renn

Dr. Melissa Shigwadja

Dr. Eric Sault

Dr. Mercedes Bomberry

No preference

Signature : _____ **Date:** _____

Please note, failure to complete this application in full will result in delays to your application!

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NEW PATIENT TRANSFER FORM

Consent to obtain records from previous Health Care Provider

I Hereby Authorize,

(Name and Address of Health Care Provider/Facility)

City

Province

Postal Code

Telephone

Fax

To disclose the following personal health information:

☐ My Entire chart

OR

☐ Specific medical information regarding:

To: _____
Physicians' name

Patient's

Name: _____ **D.O.B.** _____

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 Six Nations Family Health team and my physician, as indicated above, in connection with the disclosure of this personal health information. I also understand I MAY be charged for the transfer of records to my new physician.

Witness _____

Signed by: _____
(Patient or Substitute Decision Maker)

DATE: _____

Relationship to the patient

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Additional information:

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