Six Nations Family Health Team

Dr. J. Zacks, M.D
Dr. R. Renn, M.D
Dr. M. Shigwadja, M.D
Dr. G. Teitelbuam, M.D

Six Nations Health Services

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_____

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)

Surgery	**Year**	**Doctor**	**Hospital**

Current Health Medical History *circle all that apply*

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

Medications/Vitamins/Supplements: ***Please attach a medication list print 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	
Prevnar 13,Pneumovax	
Zostavax (shingles)	
COVID Astra Zeneca, Moderna, Johnson, Pfizer or other:_____Doses: 1,2,3,4	

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Preventative Care:

Have you had Bone Density Test?
Have you had a Prostate Test?
Have you had a Colonoscopy?
Have you used a Colon Cancer take home stool sample test?

Signature :_____ **Date:**_____

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

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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.***

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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 my new physician: (circle one)

Dr. Jason Zacks Dr. Ryan Renn Dr. Melissa Shigwadja

Dr. Greg Teitelbaum

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 hearby 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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