DR. J. AJAYI-OBE
494 Christina St. N. Sarnia, ON N7T 5W4 | Phone: 519-336-6019 | Fax: 519-336-7136

Last Name _____ First Name _____

Date of Birth (mm/dd/yyyy) _____ Age _____ Gender _____

Address (Number, Street, Apt, Unit) _____ City _____ Postal Code _____

Home Phone Number _____ Cell Phone Number _____

Email _____ Health Card Number and Two-Letter Version Code _____

Medical history (Please list current and past medical conditions - ie. Asthma, depression, heart attack, chronic pain, high blood pressure)

Please list previous surgeries and year performed

Current medications (Name, dose, frequency. Prescription and non-prescription/herbal)

Please list drug allergies and type of reaction (ie. Rash, nausea, anaphylaxis)

Please check: ☐ **NON-SMOKER** ☐ **SMOKER** (# of Yrs: _____) ☐ **EX-SMOKER** (Yr Quit: _____)

PATIENT DECLARATION

Please check the numbered statement that most closely applies to you:

☐ 1. I have moved to Sarnia-Lambton and do not have a physician in the community.

☐ 2. Until now, I have not had, or felt the need to have a family physician.

☐ 3. My previous physician has moved or retired.

☐ 4. My previous physician is still practicing, but no longer provides my care.

Name of previous/current physician: _____

Date last seen: _____ City/Province: _____

- Completion of this form does not guarantee entrance into Dr. Ajayi-Obe's practice.
- At the time of the initial appointment, if either party decides that the patient-physician relationship would be ineffective for any reason, either party my terminate the relationship at that point without further commitment.
- Dr. Ajayi-Obe will maintain a STRICT narcotic prescription policy in order to minimize the potential for abuse. Prior treatment or existing narcotic prescriptions does not guarantee that Dr. Ajayi-Obe will prescribe narcotics for you. Patients suspected of narcotic abuse will be subject to termination of the patient-physician relationship.
- Please be sure that this form is fully completed. Incomplete forms will be discarded. Please fill out a separate form for each family member, but return all forms together.
- By signing below, I acknowledge that I have read and understood the declarations and have answered all questions truthfully. If responses on this form are intentionally incorrect, the patient-physician relationship may be terminated.

Signature: _____ Date: _____

The security and privacy of your confidential health information is of the utmost importance to us; Email is not a secure method of communication. **Please print your completed application and submit in person at 494 Christina St. N. or fax to 519-336-7136**.