SARNIA MEDICAL GROUP

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 the individual family physician's practice in the SARNIA MEDICAL GROUP.
- 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.
- The individual family physician's practice in the SARNIA MEDICAL GROUP 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 the individual family physician's practice in the SARNIA MEDICAL GROUP 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**.