

PATIENT QUESTIONNAIRE

*If you currently **DO NOT** have a Family Physician, please proceed.*

Name: _____

Phone (home): _____ Work: _____

Address (Including City and Postal Code): _____

Health Card Number: _____ Version Code: _____

Health Card Expiry Date (dd/mm/yyyy): _____

Pharmacy: _____ Fax: _____

Date of Birth (dd/mm/yyyy): _____

Occupation: _____ Company: _____

Do you currently have a Family Physician? Yes: _____ No: _____

If "YES", what is their name? _____

If "YES", where is their practice? _____

If "NO", why not? _____

Have you ever been discharged/fired from a Family Practice? Yes: _____ No: _____

Describe your previous medical history:

List any current medical issues that you have, and any Specialist you are currently seeing:

What medications are you taking?

What medical procedures/surgeries have you had in the past?

This questionnaire **must be filled out completely to be considered**. Any misleading or omitted information may be grounds for dismissal. Please return completed questionnaire to **P.O. Box 130, Barrie Ontario, L4M 4S9**. The Physicians will review your information to determine whether the scope of their practice encompasses your medical needs. After careful review, patients accepted to the practice will be contacted by the office to meet for an interview, after which a final decision will be made. Questionnaires will be kept confidential. **All applicants will be considered. We do not discriminate based on age or medical condition.**

TERMS & CONDITIONS

The following serves as the Physician's philosophy of care and is indicative of how the Physician's intend to provide medical treatment to the patients in their practice to ensure a healthy doctor-patient relationship.

- Physician's anticipate opening a comprehensive primary ("family") practice.
- Physician's believe in open and honest communication between doctor and patient.
- Physician's believe in mutual respect between doctor and patient.
- Physician's believe in a "**patient-centered**" model of health care, wherein a patient takes active responsibility for his or own health with the guidance of their doctor.
- At times your care may be provided by another Physician within their group, a Nurse Practitioner associated with the practice or by other allied health professionals.
- The patient should disclose if they have sought treatment or medication from another Physician other than their Family Doctor. Patients must make every effort to contact our office first **except in emergency situations.**
- Differences of opinion regarding medical treatment and moral and ethical values will be respected, but should they affect the doctor's ability to provide adequate medical care they may require dissolution of the doctor-patient relationship.
- A list of non-insured service fees will be made available at each office.
- Patients are not accepted on a first come, first serve basis.
- **The selection process for the Physician's is in no way discriminatory and all Questionnaires will be given equal consideration.**

There is a zero tolerance policy for any harassment, intimidation or abuse of any member of our staff or Physicians. If you have questions or comments please forward them to _____ for further clarification. By signing this form, you agree to the conditions of the practice as outlined above.

Patient's Signature

Date

Physician's Signature

Date