GOSHEN MEDICAL CLINIC

105 Albert Street, Port Moody
B.C. V3H 0P2

PATIENT INTAKE HISTORY

DATE:_____

***LEGAL NAME**:_____**PREFERRED NAME:**_____
(LAST NAME, FIRST NAME and MIDDLE NAME)

***DOB:**_____ ***PHN:**_____
(DD-MMM-YYYY) (Personal Health Number – Care Card)

***GENDER:** _____ ***EMAIL:** _____

HOME ADDRESS: _____

POSTAL CODE: _____

PREFERRED PHARMACY:_____

PREVIOUS FAMILY PHYSICIAN: _____
Reason for seeking a new GP: _____

Do you have a family member in our clinic__Yes_____No_____

Provide Name and relationship of family members in our clinic:_____
_____

PHONE NUMBERS (list all contact information)**:**
Home:_____Cell:_____Work:_____

EMERGENCY CONTACT:_____
(NAME, **RELATIONSHIP** and phone number)

MEDICATIONS: (please list all medications including vitamins, etc.)_____

_____

_____

ALLERGIES: (please list all allergies including medication, environmental, food, etc.)_____

_____

Height:_____ Weight:_____

MEDICAL HISTORY: (check all that apply)

☐ Arthritis	☐ Asthma	☐ Anemia	☐ Back Pain
☐ Bronchitis	☐ Cancer_____	☐ Chest Pain	☐ Chronic Pain
☐ Constipation	☐ Depression	☐ Diabetes	☐ Diarrhea
☐ Heartburn	☐ Hypertension	☐ Migraines	☐ Coronary Artery Disease
☐ Osteoporosis	☐ Seizures	☐ Sinus Problems	☐ Stress Incontinence
☐ High Cholesterol	☐ Weight Gain	☐ Anxiety	☐ Stroke
☐ Atrial fibrillation	☐ Recurrent UTI	☐ BPH	☐ Low Ferritin

☐ Other (please list) _____

_____

_____

WOMEN: Live Births_____ Miscarriages_____

Pregnancies_____ LMP _____

SURGICAL HISTORY: (check all that apply and list the approximate year)

☐ Tonsillectomy _____	☐ Appendectomy _____
☐ Hysterectomy _____	☐ Hysterectomy and Bilateral Oophorectomy _____
☐ Cataract Surgery _____	☐ Hernia repair _____
☐ Bypass Surgery _____	☐ Surgical Fixation of a Fracture _____
☐ Knee Replacement _____	☐ Carpal Tunnel Release _____
☐ Hip Replacement _____	

☐ Other (please list) _____

_____

FAMILY HISTORY: (check all that apply)

☐ Epilepsy	☐ Migraine	☐ Mental Illness	☐ Glaucoma
☐ Diabetes	☐ Thyroid Disease	☐ Hay Fever	☐ Asthma
☐ Anemia	☐ Bleeds Easily	☐ Osteoporosis	☐ Arthritis
☐ Heart Disease	☐ Stroke	☐ Hypertension	☐ High Cholesterol
☐ Alcoholism	☐ Hepatitis	☐ Cancer	☐ Depression

☐ Other (please list) _____

_____

PERSONAL and SOCIAL HISTORY

☐ Unemployed/Disabled/on disability benefits _____

☐ Employed (occupation) _____

☐ Student (school) _____ ☐ Retired (past job) _____

☐ Marital status _____

HABITS: Smoker_____Yes How many cigarettes per day?_____
_____No When did you quit smoking?_____

Alcohol_____Yes How much per day_____ per week_____ per month_____
_____No When did you quit?_____

PREVENTIVE SCREENING TEST: (check all that apply and list the approximate year)

☐ MAMMOGRAM (Ages 40-74) _____

☐ FIT TEST (Ages 50-74) _____

☐ PAP (Ages 25-69) _____

☐ Colonoscopy _____

☐ Lung Cancer Screening /CT (for smokers Ages 55-74_____

☐ Bone Mass Density _____

☐ Last Labs _____

INSURANCE CLAIMS (ICBC/WSBC): (Please provide information of any active claim and year of claim)

☐

_____

☐

_____

PLEASE NOTE THAT BY COMPLETING AND SUBMITTING THE PATIENT INTAKE FORM DOES NOT AUTOMATICALLY MAKE YOU A PATIENT AT THIS CLINIC.
WE WILL CONTACT PATIENTS WHEN OPENINGS ARE AVAILABLE. PLEASE DO NOT CALL TO CHECK ON STATUS OF APPLICATION.
DO NOT TRANSFER YOUR MEDICAL RECORDS UNTIL REQUESTED BY THE ACCEPTING PHYSICIAN.
PATIENT NOT CONTACTED WILL BE ON OUR WAIT LIST UNTIL THERE IS FURTHER OPENINGS.
WE ENCOURAGE EVERYONE TO APPLY TO OTHER ACCEPTING CLINICS.

Ministry of Health

MEDICAL PRACTICE
ACCESS TO PHARMANET AGREEMENT

PHARMANET
Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*, R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Schedule Act*, S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I,_____, authorize Goshen Medical Clinic
Name of Patient (print) *Name of Physician (print)*

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physician.

Executed at_____, this_____day of_____, 20____.

SIGNED AND DELIVERED by)
)
)
_____)
Patient (print))
)
in the presence of:)
)
)
_____) _____
Witness (signature)) *Patient (signature)*
)
_____)
Witness (print))
)
_____)
(Dated))

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Patient Informed Consent

Dear Patient,

CONSENT TO USE MEDICAL AI SCRIBE

We are introducing Medical AI Scribe, a Health Insurance Portability and Accountability Act (HIPAA) and Personal Information Protection and Electronic Documents Act (PIPEDA) compliant tool, to enhance your consultations. It ensures accurate notetaking, allowing your clinician to focus more on you and less on manual tasks, improving your care quality.

CONSENT TO USE VIRTUAL CARE TOOLS

The Physicians has offered to provide the following means of virtual care:

Secure Electronic Communication (Email)	Telephone Calls
Text messaging (appointment reminders)	Website/Portal- for important information when available

I agree to interact with the Physician or the Physician's staff using these Services and to the use of Medical AI Scribe during consultations. I acknowledge that either I or the Physician may, at any time, withdraw the option of using the Services upon request at any time without affecting the quality of your healthcare.

Patient name:

Patient signature:	Date:

Practice Information-*please keep*

Appointments

Appointments can be made in person at the office or by calling the office phone number. We are currently working on online booking. In order to make sure we can book an adequate time for your appointment - we will ask you at the time of booking what concern/reason you are asking to be addressed. Alert us if there will be any paperwork involved as this may require more time.

Late Policy:

Call the practice if you are running late for a scheduled appointment to enable us to accommodate you on the same day or reschedule based on urgency.

Cancellation Policy:

We would like at least 24 hours for cancellation. If the practice needs to reschedule your appointment for any reason, efforts will be made to have you scheduled on the earliest available slot.

Controlled Medication:

If you are on high doses of opiates, benzodiazepines, or hypnotics it is expected that you are open to conversations regarding safe practices and willing to work together to lower these medications to a safer dose according to the college guidelines and best standard of practice. We do not abruptly discontinue long term medication without a plan that is safe for the patient.

Chaperon:

Our physicians are required to have a chaperon when performing sensitive procedures and examinations. As required by the CPSBC, they can also be required to be present at all/some patient interactions (clinic visit/ telephone) as deemed by the provider and circumstances.

Prescription Renewals:

If you take regular medication, do not allow yourself to be completely out before notifying your doctor. Endeavour to book appointments 2weeks in advance for renewals, and if we receive a refill notification from your pharmacy, we will be booking a phone call appointment for this. Drug refills can be discussed with your physician.

Termination of the Physician-Patient Relationship:

Be aware that termination of the physician-patient relationship may occur in the following situations:

1. Harassment and/or violence towards staff, physician or other patients.
2. Significant breakdown in the physician-patient relationship, including irremediable differences in philosophy of care.

Uninsured Services Package:

You will be billed for any services that are not covered by Medical Service Plan (MSP). Please notify the clinic ahead of time.