Rapids

Family Health Team

Contact and Medical Information Sheet

Last Name	Given Name(s)	Preferred name
Date of Birth (mm/dd/yyyy)	Age	Gender
Address: Number & Street		Apt. Number
City	Postal Code	Health Card Number
Home Phone Number	Cell Phone Number	Other Contact Number

Medical History (attach additional page(s) if necessary):

Please list current medical conditions (i.e., asthma, depression, heart attack, etc.)

Please list significant past health issues including surgeries:

Please list current prescription, non-prescription and herbal medications:

Please Turn Over

Please list any drug allergies and type of reaction (i.e. rash, nausea, anaphylaxis):

_____

_____

_____

Name of previous physician:_____

Date last seen: _____ **Location (city):**_____

PLEASE NOTE:

- **Completion of this form does not guarantee entrance into a family practice at Rapids Family Health Team.**
- **At the time of the initial appointment, if either party decides that the patient-primary care provider (i.e. NP and/or Dr.) relationship would be ineffective for any reason, either party may terminate the relationship at that point without further commitment.**
- **Rapids Family Health Team maintains a strict narcotic prescription policy in order to minimize the potential for abuse. Narcotics will only be prescribed for legitimate pain control purposes. Extended/prolonged narcotic use will require patients to sign a narcotic use contract. Patients suspected of narcotic prescription abuse will be warned and subject to discharge from the primary care practice.**

Please complete this form as fully as possible. Please fill out a separate form for each family member, but return all forms together.

By signing below, I acknowledge I have read and understood all policies and procedures, as well as answered all questions truthfully. I understand Rapids Family Health Team is a respectful workplace where harassment against any employee will not be tolerated.

_____

Signature **Date**

For Office Use Only: Date Received