East City Medical Centre

Walk-In Clinic and Family Practice
4-880 Armour Road, Peterborough, ON, K9H 2A6
Phone: 705-740-1695 | Email: info@eastcitymedicalcentre.com

NEW PATIENT APPLICATION

Date (YYYY-MM-DD): _____

PERSONAL INFORMATION

Last Name (Surname): _____

First Name (Given Name): _____

Birth Date (YYYY-MM-DD): : _____ : _____

_____

Gender: ■ Male ■ Female ■ Other (see below)

Gender Identity (optional): _____

Street Address: _____ **Suite / Apt. #:** _____

City: _____ **Province:** _____ **Postal Code:** _____

Coverage type: ■ OHIP ■ Other Canadian Province ■ Private Insurance ■ Self-Pay / Uninsured

Health Card Number (OHIP, other provincial, or international ID):

_____

Version Code: _____ **Health Card Expiry Date (YYYY-MM-DD):**

_____

CONTACT INFORMATION

Home Phone: _____ **Business Phone:** _____

Mobile Phone: _____ **Email:** _____

We will contact you for your first appointment via email. If you prefer another method, please check one:

■ Home Phone ■ Business Phone ■ Mobile

Preferred appointment time:

■ Any time of day ■ Morning only ■ Afternoon only

Preferred language for care: ■ English ■ French ■ Hindi ■ Gujarati ■ Other: _____

I authorize East City Medical Centre (ECMC) to contact me at the email address listed above for appointment reminders and clinic information.

No-Show Policy: If you do not attend your booked appointment or cancel within 24 hours, a $75 no-show charge will apply.

EMERGENCY CONTACT

Contact Name: _____ **Relationship:** _____ **Phone Number:** _____

MEDICAL HISTORY — Check all that apply

■ Asthma	■ Angina / Chest Pain	■ Anemia
■ Arthritis	■ Glaucoma	■ Cancer
■ Chronic Bronchitis	■ Cirrhosis	■ Clotting Disorder
■ Diabetes	■ Emphysema	■ Gallstones
■ Heart Attack	■ Heart Murmur	■ Headaches
■ Hepatitis	■ High Blood Pressure	■ High Cholesterol
■ HIV Positive / AIDS	■ Kidney Disease	■ Kidney Stones

■ Migraines ■ Stroke ■ Thrombophlebitis

■ Thyroid Disease ■ Tuberculosis ■ Ulcers

■ Rheumatic ■ Positive TB Test ■ Fractures

■ Fever ■ Epilepsy ■ Other – list below

■ Currently pregnant ■ Planning pregnancy ■ Postpartum (within 12 months)

■ Depression ■ Anxiety ■ ADHD ■ Sleep disorders ■ Substance use disorder

Other (specify): _____

FAMILY HISTORY — Check if a blood relative has had any of the following

Please indicate the relationship (mother, father, sibling, etc.).

■ Bleeding Tendency ■ Liver Disease ■ Heart Attack

■ Tuberculosis ■ Kidney Disease ■ Diabetes

■ Stroke ■ Hypertension ■ Cancer

■ Migraines ■ Heart Disease

Relationship / Notes: _____

OPERATIONS AND / OR HOSPITALIZATIONS

Reason: _____ **Date (YYYY-MM-DD):** _____

Reason: _____ **Date (YYYY-MM-DD):** _____

Reason: _____ **Date (YYYY-MM-DD):** _____

CURRENT MEDICATIONS

Medication name / dosage: _____

Medication name / dosage: _____

Medication name / dosage: _____

ALLERGIES TO MEDICATIONS

Allergy / Reaction: _____

Allergy / Reaction: _____

PREVIOUS PHYSICIAN

Previous Family Doctor Name: _____ **Clinic Name:** _____

City: _____ **Phone Number:** _____

Reason for seeking new family doctor (optional): ■ Moved to area ■ Previous doctor retired ■ Previous doctor full ■ Other

Are other family members also applying? ■ Yes ■ No

If yes, names: _____

HOW DID YOU HEAR ABOUT US?

■ Google ■ Walk-by ■ Friend / Family ■ Social Media ■ Other: _____

CONSENT AND AUTHORIZATION

I understand that East City Medical Centre collects my personal health information for the purpose of providing medical care. My information will be kept confidential in accordance with Ontario's Personal Health Information Protection Act (PHIPA). I consent to the collection, use, and storage of my health information as described. I also acknowledge the no-show policy stated above.

Patient Signature: _____ **Date (YYYY-MM-DD):** _____

Print Name: _____

For patients under 18:

Parent/Guardian Signature: _____

Date (YYYY-MM-DD): _____

Print Name: _____

Relationship to Patient: _____