# 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:** ______________________________