CENTRAL LAMBTON FAMILY HEALTH TEAM

Dr. J. Butler Dr. E. Daniel Dr. F. Al-Dhaher,
Dr. J. Mall Dr. N. Taylor Dr. S. Cooper,
Dr. A. Leonard Dr. A. Hijazi Dr. P. Moon

4130 Glenview Ave., Unit 3
Petrolia, Ontario N0N 1R0 519-882-2500

Welcome to Central Lambton Family Health Team.
In order to serve you better, we ask that you complete the following:

Name:____

Complete Mailing address: - Please include 911 number or P O Box

____

____

____

Cell phone # (if applicable) ____________________________

Employer Name ____________________________________ Phone #____________________

EMERGENCY CONTACT:

Name: ____ Phone #_____________________

Relationship: ____

ALTERNATE CONTACT:

Name: ____ Phone #_____________________

Relationship: ____

PHARMACY USED FOR PRESCRIPTIONS

Pharmacy Name _____________________________ Location ____________________________

Previous Doctor _______________________________ Location _______________________________

We ask that you inform our office of any changes to the above information.

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REQUEST FOR MEDICAL RECORDS

Dear Dr: ______________________

The following patient has come under the care of Dr.______________________

( ) and would like a copy of his/her medical records transferred

( ) **does NOT wish** to have his/her medical records transferred and wishes to notify you of change ONLY

PATIENT : ______________________

DATE OF BIRTH: ______________________

OHIP NUMBER: ______________________

CURRENT ADDRESS: ______________________

____

TELEPHONE: ______________________

I agree to release my medical records to Dr. ______________________.
I understand that there may be a charge for the transfer of records and I am aware that I will be responsible for any fees associated with transfer.

____
Patient signature (print name beside signature)

____
Witness (print name beside signature)

____
Date

____
Date

Central Lambton Family Health Team
4130 Glenview Road, Unit 3
PETROLIA, Ontario N0N 1R0
Telephone 519-882-2500 Fax 519-882-4321

Contact and Medical Information Sheet

Surname ____________________ Given Name (s) ____________________

Date of Birth ____________________ Age __________ Gender (circle) Male Female

Address: Number and Street ____________________ Apt Number __________

City ____________________ Postal Code __________ Home Phone No. __________

Alternate Contact No. (eg cell) __________ Type (ie. Work, cell) __________ Health Card Number __________

MEDICAL INFORMATION

Y	N	Diabetes: Type 1 Type 2	Y	N	Irritable Bowel Syndrome
Y	N	High Blood Pressure	Y	N	Heartburn, Indigestion, GERD
Y	N	High Cholesterol	Y	N	Crohn's Disease, Colitis
Y	N	Chest Pain, Angina	Y	N	Chronic Headaches
Y	N	Heart Failure	Y	N	Thyroid Disease: Hypothyroidism hyperthyroidism
Y	N	Heart Attack, when	Y	N	Lupus
Y	N	Emphysema	Y	N	Kidney Disease
Y	N	Asthma	Y	N	Hernia
Y	N	Problems with ears, eyes, nose	Y	N	Urinary/Bowel Incontinence ostomy colostomy
Y	N	Arthritis, joint pain: knees hips ankles wrist hands back Other:	Y	N	Have you ever had: Blood Clot, Deep Vein Thrombosis, Pulmonary Embolism
Y	N	Chronic Back Pain	Y	N	Fibromyalgia
Y	N	Anemia	Y	N	Skin Condition
Y	N	Sleep Apnea	Y	N	COPD
Y	N	Cancer	Y	N	Stroke
Y	N	Mental health issues: Anxiety Depression Panic attacks Bipolar Psychosis Schizophrenia PTS Other	Y	N	Other:
Y	N	Smoker Years smoking ______ Ex-smoker Year quit __________ If currently smoker, I would like to quit smoking (circle) yes no	Y	N	Drug Allergies : list and type of reaction (rash, nausea, anaphylaxis)

MEDICATIONS

Name	Dose	Frequency

PAST SURGERIES	DATE

FAMILY HISTORY OF SIGNIFICANT MEDICAL ISSUES EXAMPLE *diabetes*	RELATION *father*

Patient Declaration

Due to the current family doctor shortage, Patients without a current family doctor within Sarnia Lambton will be given a priority. Please check the box that most closely applies to you:

- ☐ My previous family physician has retired or moved
- ☐ My previous family physician is still practicing but no longer provides my care.
- ☐ Until now, I have not had or felt the need to have a family physician
- ☐ I have relocated to Sarnia-Lambton and do not have a family physician in the Community
- ☐ Other____

Name of previous/current family physician: ____________________________________

Date last seen: ________________________ Location:______________________

PLEASE NOTE:

- Completion of this form does not guarantee entrance into our practice.
- **Central Lambton Family Health Team will maintain 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 prescription abuse will be warned and subject to termination of the patient-physician relationship.**

Please be sure this form is fully completed. Please fill out a separate form for each family member and 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. If responses on this form are intentionally incorrect, the patient-physician relationship may be terminated.

______________________________ ________________________

Signature Date