Dorset Health Hub Intake Form

Patient Information **Date:** _____

Surname: _____ First Name & Middle Name: _____

Health Card #_____ Version code: _____ Expiry: _____

Gender (circle) M F Date of Birth: _____ Age: _____

Address: _____Town:_____ Province/State: _____ Postal/Zip code: _____

Home Phone/cottage phone: _____ Cell Phone: _____

Emergency contact: Name and phone number: _____

Relationship: _____

O -Yes, I agree to share personal health information with this person

O -No, please only share information in case of an emergency

Primary Care Provider Information

I have a family doctor or nurse practitioner: YES / NO

When did you last see your MD/NP: _____

I am interested in the DCHH NP becoming my primary care provider: YES / NO

Please provide name and address of previous MD/NP

_____

Health History

Please check all that apply:

Arthritis: ___ Asthma/COPD: ___ Smoker: ____ Heart problems (angina, Heart attack, CHF): ____

Hypertension: ___ Diabetes: ___ Mental illness: ____ Musco-skeletal problems: ____ other: ____

If you checked other or would like to provide any further information please do so below:

Allergies: _____

Surgeries (last 10 years): _____

Medications (including supplements, over the counter, Rx creams and eye drops):

_____

_____

_____