CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date Of Birth:_____
Last Middle First M/D/Y

Health Card: _____ Version Code:_____

Address: _____

City: _____Postal Code:_____

Home Phone#: _____Cell: _____

Work #: _____ Email:____ _____

Occupation:_____

Emergency Contact: _____ Phone: #:_____
Relationship: _____

Family Physician: _____
Address: _____City: _____
Phone Number:_____Fax Number: _____

Referring Physician: _____
Address: _____City: _____
Phone Number:_____Fax Number: _____

Primary Sports/Activities:_____

If WORK RELATED and open WSIB claim, please fill in below and WSIB FORM 8

(Please ask Secretary):

WSIB CLAIM #: _____SIN#:_____

If open MOTOR VEHICLE ACCIDENT claim, Please fill out and sign OCF-5 Form and OCF-18

(Please ask Secretary):

PLEASE COMPLETE REMAINDER OF MEDICAL INTAKE ON NEXT PAGE(S)

PLEASE COMPLETE FOLLOWING 2 PAGE MEDICAL QUESTIONNAIRE REGARDING YOUR CONDITION AND MEDICAL HISTORY. THANK YOU.

DATE:_____NAME:_____SEX:_____AGE:_____

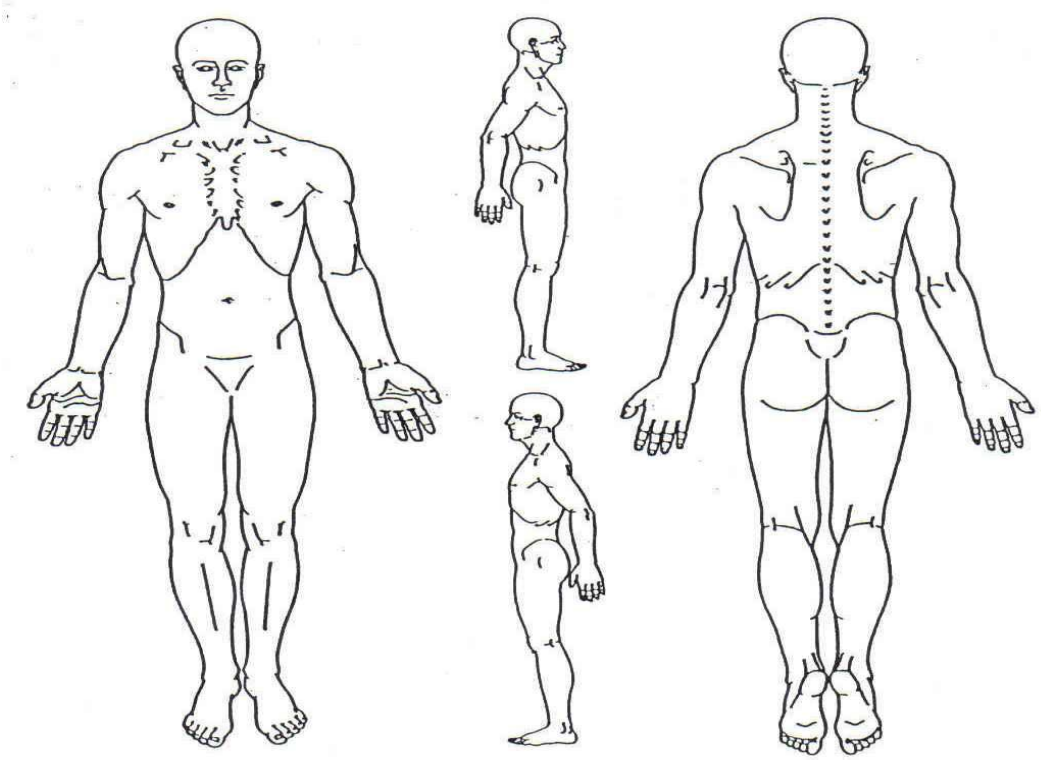
R or L handed ? Occupation:_____Sports/Activities:_____

Please mark on the diagram below the main (ie. only one please) area where you are experiencing symptoms and please describe the symptoms with the letter codes below:

Numbness = N
Sharp Pain = P

Tingling = T
Burning = B

Dull Pain = D
Stiffness = S



How long have you had this condition?

If there was an injury, please describe mechanism:

If there was no injury, how do you think your condition developed?

Please list any associated symptoms if any (eg. Weakness, swelling, loss of function, etc.)

Please list movements, activities, factors that makes your condition worse:

Please list anything that makes your condition feel better:

Name:_____ Date:_____

Please list all investigations/tests/imaging you have had for your condition, when it was done and indicate the results of each if known:

Please list all treatments/therapies/medications/procedures that you have tried for your condition. Please indicate how many times/how long you tried each, when this took place, and the percentage improvement if any from each:

Please list the medical/health care practitioners you have seen re. your condition and what did they indicate the diagnosis (if any) and recommendation(s) (if any).

Please list ALL present and/or past medical condition(s), serious injuries, surgeries, hospitalizations etc. you may currently or have had previously in your life:

Please list ALL medications and supplements you are currently taking:

Please list any medications or medical devices (eg. Latex, tape) you are allergic to:

Please list any past/present psychiatric history and/or history of alcohol/chemical/ substance dependency (please specify what substance):

If female, are you currently or planning to become pregnant or breast feeding ? Y or N

Signature: _____ Date:_____

NOTICE OF NON-OHIP CHARGES: Please read and choose either OPTION A) OR B) below

OPTION A): Please note NON-OHIP charges will be levied as per fee schedule below and the patient is responsible for these charges as it is incurred or required:

1. Missed appointments without 24 hours notice.
   - $100.00 Initial consultation
   - $50.00 Follow-up visits

2. Telephone prescription renewals.
   - $20.00 each

3. Simple "sick" notes hand written on letterhead or Rx pad (eg. work, school, gym membership, camp, etc.).
   - $20.00 each

4. Forms for work, school, insurance, government, disability etc.
   - $50.00/page and up, depending on complexity.

5. Official Medical Reports for third parties (eg. Insurance, lawyer, employer, etc.).
   - Time dependent charge at $400/hr and up depending on complexity. Please discuss with Dr. Su.

6. Medications and medical devices dispensed/given by Dr. Su directly to patient.
   - Depending on circumstances and drugs used, please discuss with Dr. Su.
   - (NB: Most drugs and medical devices **MAYBE COVERED** by extended health plans).

7. Officially signed prescriptions for insurance or other 3rd parties for the purposes of obtaining coverage:
   - Minimum $40.00 and up.

8. Copies of clinical notes, records, investigations, letters etc.:
   - Minimum $40.00 and up depending on nature of information requested. Please discuss with Dr. Su.

9. Confirmation to third parties re. date(s) of attendance:
   - Minimum $40.00 and up.

OPTION B): An annual "Block Fee" is available for purchase that would cover some NON-OHIP charges outlined above. The block fee will be $100.00 and will be valid from the date the patient signs up and pays for the fee until the anniversary from that date. The block fee will include the following service(s):

Unlimited items **2, 3, 7, 8, 9** and 50% discount for items **4, 5** from **OPTION A)** above.

Up to 3 (three) missed appointments without charge as per item **1** from **OPTION A)** above.

Please circle and sign and date which option you would like to choose: A) or B)

NB: At this clinic, MD fees can only be accepted as *direct cash* or *certified cheque*. Thank you.

_____	_____	_____
Name (Please print)	Signature (Guardian if < 16 yo)	Date