Vineyard Medical Clinic

***PATIENT INTAKE FORM***

LAST NAME:_____ FIRST NAME:_____

BIRTHDATE MONTH:_____ DAY:_____ YEAR: _____ GENDER: _____

ADDRESS:_____ CITY/PROVINCE:_____ POSTAL CODE:_____

*Please CHECK which one below is the primary phone number*

| | | |
|---|---|---|
| HOME PHONE NO.: | | ✓ ✗ |
| WORK PHONE NO.: | | ✓ ✗ |
| CELL PHONE NO.: | | ✓ ✗ |
| EMAIL ADDRESS: | | |

EMERGENCY CONTACT NO.: _____ Next of Kin name:_____ Relationship Status:_____

Do you have Family Doctor? *If YES please specify:* _____

Do you have any allergies? *If YES please specify:* _____

**** PLEASE COMPLETE FORM AND RETURN TO RECEPTION WITH YOUR HEALTH CARD AND ID ****

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