Niagara Medical Group
Family Health Team

4421 Queen Street,
Niagara Falls, On L2E 2L2
(905) 356-2236

New Patient Information Package

Please find enclosed the necessary information we will need for you to complete **prior** to accepting you as a patient.

Please follow the instructions carefully. Print clearly and legibly. Incomplete forms will result in a slower process.

1) Please date and put your name on **ALL** pages. Forms will be processed in order in which they are received.

2) **A set of forms must be completed for each family member**.

3) Ensure your Health Card is Valid (check Expiry date), the number is correct and include the version code (2 letters at the end of the number).

4) Please be **Honest** on all Personal/Medical History.

5) List as many surgeries and medical history as you can recall (specific dates not necessary, an approximately year would be sufficient).

6) If you are currently taking any prescription medications **we will require a Pharmacy Print Out, (Must be submitted with this form).**

Niagara Medical Group adheres to a Strict Policy regarding NARCOTIC MEDICATIONS. No patient will be prescribed narcotic medications without previous medical investigation, documentation and only at the Doctor's discretion.

7) Immunization records required for all children under the age of 16 **please provide photocopy**. (If you do not have a record for your children, Public Health will be able to provide you with one.)

8) Transfer of records from other Physicians will be done only when necessary.

9) Return entire package as soon as possible. **We will call you when your paperwork has been processed and a Dr. has been assigned to you.**

Enclosed is information from the Ministry of Health, general information about our office and programs we offer. Please take time to review **and/or** visit our website.
Website: www.NiagaraMedicalGroup.com

Patients currently without a family Doctor or patients with a family Doctor outside the Niagara Region will be given priority.

For all New Patient enquiries and appointments contact:
Ext # 243

Niagara Medical Group
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Dr. R. M. Guise, M.D.,F.C.F.P.
Dr. J. M. Morin, M.D.,C.C.F.P.
Dr. E. Wassif, M.D.,C.C.F.P.
Dr. E. Zufelt, M.D.,C.C.F.P.
Dr. R. Hogg, M.D.,C.C.F.P.
Dr. C. Russell, M.D.,C.C.F.P.
Dr. A. Brar, M.D.,C.C.F.P.
Dr. K. Tenhoeve, M.D.,C.C.F.P.
Dr. J. Kho, M.D., C.C.F.P.

4421 Queen Street
Queen Street Medical Building
Niagara Falls, ON L2E 2L2
Phone: (905) 356-2236
Fax: (905) 356-2568
www.niagaramedicalgroup.com

Regular Office Hours

Monday: 9:15 – 7:30
Tuesday – Thursday: 8:30 – 7:30
Friday: 8:30 – 12:30 and 2:00 – 6:30
Saturday: 9:00 – 12:30

Office Extensions

Appointments/Switch Board Ext# 0
Business Office Ext # 223
Workshop Registration Ext # 274
Program Secretary (Nutrition, Chiropody) Ext # 265
Prescriptions Ext # 276
Lab Ext # 252
New Patient Information Ext # 221
Referrals Ext # 227 or 305

Urgent Care Clinic (On Premises)

Monday – Thursday: 11 a.m.-12 and 2:00 – 7:30
Friday: 11 a.m. – 12 and 2:00 – 5:00
Saturday: 9-12:30 a.m.
Same Day Bookings, By Appointment Only (NO Walk-Ins) Care Provided by our Physicians and Nurse Practioners

Urgent Care problems are considered – Workplace Injuries, cough, cold, sore throat, ear and eye infections, rashes and minor acute problems, etc…. Please Note: In cases of severe shortness of breath, chest pain, and all fractures you should call 911 or go directly to your local Emergency Department

*** *PLEASE NOTE:* *Due to Urgent Care Clinics being provided on promises, we ask that you* ***

DO NOT USE Walk-In-Clinics. ***The physicians of the group will be negated (required to pay) for the services you receive at Walk-In-Clinics. Also, the Walk-In-Clinics are not obligated to provide your physician with any information collected at your visit.***

Services Available to all Enrolled Patients (On Site)

Wellness and Prevention Program
Workshops on a variety of health-related issues
Collaborative Care Management
Mental Health Counseling
Chronic Disease Management
Laboratory and ECG Services
Chiropody
Healthy U Program
Psychiatric Services
Smoking Cessation Program
Nutrition/Dietician Services
Nurse Practioners

Affiliations with Community Agencies: such as Arthritis Society of Canada and Heart Niagara

Prescription Repeats and Renewals

If you require a repeat or renewal of your prescription, please have your pharmacy fax a request to our office and allow 24-48 hours, for our office to process.
It its recommended that each patient deal with one pharmacy, this is to provide more continuity and better health care.

Test Results

Due to the volume of test results the office will only notify you of abnormal results. If you do not hear from the office and wish to discuss your results you can book an appointment with you Doctor.

After Hours Service

When contacting our office after hours, you will be directed to either the answering service or the Telephone Health Advisory Service (THAS). A THAS Registered Nurse will triage your condition over the phone and direct you to the appropriate services at that time. Your Physician will be provided with a report of all telephone inquiries that are directed to THAS.

****** IF YOU MISS YOU INITIAL APPOINTMENT YOU WILL NOT BE ACCEPTED INTO THE PRACTICE*******

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New Patient Application

Name:_____(as it appears on your Health Card)
Preferred/Chosen Name:_____ Pronouns:_____
Date of Birth :_____/_____/_____ Age:_____
Health Card #:_____ Version Code:_____
Expiry Date:_____/_____/_____ Sex Assigned at Birth:_____ Gender:_____
Address: _____
City _____ Postal Code:_____
Home Phone # _____ Work #_____Cell # _____
Emergency Contact and/or Next of Kin_____
Home Phone # _____ Work #_____Cell # _____

Which of the following best represents your racial or ethnic heritage? (Circle all that apply)

White	**Black/African American**	**West Asian/Arab**	**Latin American/Hispanic**	**South Asian**
Indigenous/First Nations	**Metis**	**Inuit**	**East/Southeastern Asian**	**Other:**

In which language would you most prefer your care? _____
Are you currently under the care of a Primary Care Provider: Yes No
Previous Primary Care Provider:_____
Address _____
City _____
Marital Status: (Circle) Single Married Widowed Divorced Separated Common-Law Partnered
Who do you live with? (Circle all that apply) Self Spouse Children Parents Grandparents
Occupation: _____ Full Time / Part Time
Are you a student Yes No
School _____ Grade _____

Personal History

Smoker YES / NO
Please indicate: (circle) Cigarettes Cigars Pipe Vape Chew
If yes: # per day/amount _____ How long have you been a smoker _____
Have you ever tried to quit smoking YES / NO
Alcohol YES / NO
Would you normally drink: (circle) Beer Wine Liquor
If yes: # of drinks_____ per week / per month
Cannabis and other drug use YES / NO
Please indicate drug and frequency_____
Do you follow any special diet? Yes No
(e.g.: vegetarian, low salt, high fiber, diabetic, celiac, iron, etc.) _____
Do you exercise? Yes No
If yes what kind of exercise do you do (e.g. Walking, Cardio) _____
Frequency and Duration (e.g.: 3 times per week for 30 minutes) _____

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Allergies

Do you have any allergies? Yes No

If yes please list and tell us about your reaction_____

Past Medical and Surgical History

Have you ever had Surgery? Yes No

Surgery	Year	Doctor	Hospital

Have you ever had any broken bones? Yes No
(If Yes please list and include year)

Bone	Year

Have you ever been hospitalized for any other reason?

Year	Reason	Hospital

Please list all current/ongoing Medical Conditions

Are you currently under the care of any **other Health Care Professional(s)** … YES / NO

(Specialist, Physiotherapist, Chiropractor, Mental Health, Addictions Counselor, Weight Loss Centre, Naturopath, etc.)

If yes, please list _____

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Prescription and Over-The-Counter (include vitamins/herbal) Medications

Name	Dosage	Directions

What Pharmacy do you deal with (Please provide location) _____

Immunizations (Please Provide Immunization Record if you have one)

When did you last have a Tetanus Shot _____/Unknown

Please tell us about other vaccinations you have ad (e.g.: Gardasil, Hepatitis, or Travel)

_____

Family History	Mother	Father	Aunts	Uncles	Brothers	Sisters	Grandparents

Please feel free to use this space to tell us anything that may not have been covered, or any **current problems or concerns** you would like to discuss with the Doctor in the near future.

_____

_____

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