New Patient Intake and Practice Policy Form

375-3066 Shelbourne St, Victoria, BC V8R6T9, Canada
T: +1-250-595-1363 F: +1-250-595-2627 W: perpetualhealthcentre.com

Please fill out all fields to the best of your ability. You may drop the forms off at our clinic. You may also go to our website at https://perpetualhealthcentre.com and sign the Virtual Clinic Consent Form to consent to use our virtual communication system. Then you can email these completed forms to contact@perpetualhealthcentre.com.
Your answers on this form will be kept confidential, and they will help your physician get an accurate history of your medical concerns and conditions.
Once received we will contact you with a New Patient appointment date & time. Thank you!

Date this form was completed: _____

Full Legal Name (as listed on Driver's License): _____

Preferred First Name: _____

Date of Birth: _____ CareCard Number: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Address: _____

Emergency Contact Name and number: _____

Referred by: _____

Medical History

Height: _____ Weight: _____

Previous Physician(s)'s name: Please list all and include the year you last saw each doctor):

_____

Do you see any Specialist doctors? Please list their name and specialty:

_____

_____

Do you have any ongoing medical conditions? (hypertension, diabetes, high cholesterol? etc.)

_____

_____

Childhood Illness: Have you ever had chickenpox? _____

Immunizations: (Please include dates if known)

Tetanus within past 10 years: _____

Pneumonia: _____ Chickenpox:_____

Shingles: _____ Hepatitis (A, B, Both or Unsure) _____

Operations/Procedures

Type of Operation or Procedure	Reason	Year

Other Hospitalizations

Name of Hospital	Reason	Year

Other Major Past Problems/Injuries

Description of Problem or Injury	Outcome	Year

Obstetrical History (if applicable):

Total Pregnancies: _____ Miscarriages:_____

Term Deliveries: _____ Pregnancy Terminations: _____

Preterm Deliveries: _____ Living: _____

Obstetrical Complications: _____

What allergies do you have - medications or substances (attach a list for additional items):

1. _____ Type of reaction: _____
2. _____ Type of reaction: _____
3. _____ Type of reaction: _____

What medications and supplements do you take? (attach a list for additional items)

(If you are unsure or unable to list - please bring all your medications to your first appointment):

1. _____ Strength: _____ Dosage: _____ For: _____
2. _____ Strength: _____ Dosage: _____ For: _____
3. _____ Strength: _____ Dosage: _____ For: _____
4. _____ Strength: _____ Dosage: _____ For: _____
5. _____ Strength: _____ Dosage: _____ For: _____

Family History

Father: Age: _____ Deceased / Living
Mother: Age: _____ Deceased / Living
Brother: Age: _____ Deceased / Living
Brother: Age: _____ Deceased/Living
Brother: Age: _____ Deceased / Living

Sister: Age: _____ Deceased / Living
Sister: Age: _____ Deceased / Living
Sister: Age: _____ Deceased / Living

Please indicate relationship and approximate age of onset for blood relatives with any of the following conditions:

Disease	Relationship/ Approximate Age of Onset
Heart disease	
High cholesterol	
Diabetes	
Asthma	
Stroke	
Dementia/Alzheimer's	
Osteoporosis	
Psychiatric problem	
Cancer (indicate type)	
Other	

Personal Social History

Occupation/student:_____Employer/school: _____

Past Occupations:_____Employer: _____

Are you: retired/unemployed/leave of absence/disabled/other: _____

Marital status: Single, Partner, Married, Divorced, Widowed, other: _____

Do you have any family members in our clinic? Who are they? _____

_____

Recreation/Hobbies: _____

Religion: _____

Lifestyle:

What best describes your diet:____VERY POOR____POOR____FAIR____GOOD____EXCELLENT

Type of diet _____

What best describes your activity level:____MINIMAL____POOR____FAIR____GOOD____EXCELLENT

Type of exercise walking, swimming

Tobacco:

What is your smoking status:____NEVER SMOKED____SMOKER____EX-SMOKER____PASSIVE SMOKE CONTACT

Cigarettes – number/day:_____Year Stopped:_____

Alcohol:

What best describes your drinking habits:____NONE____LIGHT____MODERATE____HEAVY____EX-DRINKER

How many drinks per day on average:_____
Year Stopped:_____
Are you concerned about the amount you drink?_____
Have you considered cutting down?_____
Are you prone to "binge" drinking?_____
Have you ever had a problem with alcohol?_____

Recreational Drugs:

What best describes your recreational drug use:_____NEVER_____EX-USER____LIGHT_____MOD____HEAVY

If yes, have you inject with needle? _____
What drugs have you used?_____
How often do you usually use?_____
Date last used? _____

Sex

Sexual Orientation? _____
Are you sexually active ? _____
Are you using contraception? _____
If yes, what contraceptive method do you use? _____
Are you on Hormone Replacement Therapy?_____

PREVENTION AND WELLNESS

Preventive Screening Tests (Please give approximate dates for the following)

***Women only:**

(ages 25-69) Date of last pap (recommended every 1 to 3 years): _____

(ages 40-74) Date of last mammogram (recommended every 1 or 2 years): _____

Both:

(>50 years old) Date of last stool test for colon cancer (recommended once a year): _____

(>50 years old) Date of last cholesterol test: _____

Perpetual HEALTH CENTRE

375–3066 Shelbourne St, Victoria, BC V8R6T9, Canada
T: +1–250–595–1363 F: +1–250–595–2627 W: perpetualhealthcentre.com

CODE OF CONDUCT and PRACTICE POLICIES

To ensure a strong start to the physician-patient relationship, the Code of Conduct and Practice Policies are outlined below.

Code of Conduct

Patients are welcome to be a part of our practice regardless of their religious affiliation, race, primary language, country of origin, physical/cognitive abilities, sexual orientation, gender identity, relationship status or socioeconomic position.

We will try our best to use the most up-to-date medical information to guide and personalize your care. We encourage full transparency during all the visits. Full honesty allows us to provide the best care possible.

Confidentiality is a patient right, and your personal information will be protected. There are, however, rare circumstances in which information collected during your visits may be shared with the appropriate authorities (namely if there is a concern RE: your imminent personal safety, or the safety/abuse of minors/dependents/ elders).

Our physicians at Perpetual Health Centre expect respect for all members of the medical team. We have a zero-tolerance policy for harassment of any sort. Any acts of harassment and/or violence towards the physicians, staff members, learners or other patients will not be tolerated and will result in an immediate discontinuation of the therapeutic relationship and termination from the practice.

Practice Fee Structure

Enrolling in our family practice provides you with:

- Comprehensive family practice medical care including annual physical, preventative health care, chronic disease management and urgent walk-in care for minor illness care.
- Access to a family physician when required by you.
- 24 hours to connect with a family physician for urgent primary care concerns which are not appropriate for ER.
- Maximum 72 hours to see a family physician.
- Out of hours service available via initial telephone triage.
- A yearly physical assessment.
- Initial blood test checking - Additional blood tests and all diagnostic tests will be paid privately by the client.

Our annual enrollment fees are based on whether you have simple or complex medical issues. Fees are reduced for families with younger children under 14 years of age.

Non-Complex Client - **$2500** /year/client
Complex Client - **$3500** /year/client
Family with children under 14 years - **$5000**/yearly

All payments are expected to be made by the clients before services are provided. Fees are non-refundable.

The annual enrollment fee is charged yearly per patient.

You can choose to withdraw membership at the end of each year.

Official receipts will be provided for the service and payment.

Call or visit our website for more information and to book a pre-enrollment appointment.

Note:

Pay per consultation is not our preferred model as we would like to build relationships with our clients instead of offering episodic care. The reason we have de-enrolled is to provide holistic care which episodic care does not encourage. Contact the practice for any further question regarding billing.

Appointments

Appointments can be made in person at the office or by calling the office phone number. In order to make sure we can book adequate time for your appointment - we will ask you at the time of booking what concern/reason you are asking to be addressed. Alert us if there will be any paperwork involved as this may require more time.

Late Policy:

Call the practice if you are running late for a scheduled appointment to enable use accommodate you on the same day or reschedule based on urgency.

Cancellation Policy:

We will like at least 48 hours for cancellation. If the practice needs to reschedule your appointment for any reason, efforts will be made to have you scheduled on the earliest available slot.

Controlled Medication:

If you are on high doses of opiates, benzodiazepines, or hypnotics it is expected that you will be willing to work together to lower these medications to safer doses. We do not abruptly discontinue long term medication without a plan that is safe for the patient.

Vaccinations:

Our clinic advocates and believes that all our patients have their routine childhood and adult vaccinations. If you or your children have not received their set of routine vaccinations, we encourage you to make arrangement to do so. This is to protect you and also protect our other patients who may be immunocompromised or at risk of serious harm if they were to contract a communicable illness.

Training Practice:

Our physicians are interested in training the next generation of physicians. We ask that if medical trainees are present, you consider participating in their learning experience. However, this is optional and not a requirement to register as one of our patients.

Prescription Renewals:

If you take regular medication your doctor may give you a repeat prescription without the need for you to be seen each time in the surgery. We have a strict policy of asking patients to allow 72 hours (2 working days excluding weekends) from ordering to collecting their repeat prescriptions.Patients on stable repeat medication can also opt for the “Batch Prescribing Scheme” which allows the patient to have up to an annual supply of prescriptions which are taken to the chemist of your choice.Drug prescribing of benzodiazepine and opiates: The practice has a policy not to issue repeat prescriptions for benzodiazepine medications such as Diazepam, Temazepam, clonazepam, zopiclone and opiates on repeat. Anyone in need of such medication on a regularly basis will be reviewed more frequently and were necessary, discussion will be held regarding ongoing use.

Termination of the Physician-Patient Relationship:

Your medical fee is non-refundable. You can choose to terminate your agreement at the end of each billing year. A 3 months' notice is required to allow for safe transfer of care and record. Be aware that termination of the physician-patient relationship may occur in the following situations:

1. Harassment and/or violence as described above.
2. Significant breakdown in the physician-patient relationship, including irremediable differences in philosophy of care

The Practice will bill the patients annually on the anniversary of the patient's enrollment for the Service. During the 12-month period after the patient signs an acceptance and enrolls with the Service, the Practice may terminate the Service if the patient is in breach of the Practice Code of Conduct and failure to pay their annual fee by the renewal date.

The annual medical fee is nonrefundable.

By signing this document, you are declaring that you have read this document in its entirety and are willing to abide by the Code of Conduct and Practice Policies while enrolled as a patient of Perpetual Health Centre. You are certifying that to the best of your knowledge all the information you have furnished on this form is complete, true, and accurate.

DATE OF SIGNING:

DATE OF SIGNING:

PRINTED NAME OF PATIENT/GUARDIAN:

SIGNATURE OF PATIENT/GUARDIAN: