PATIENT INTAKE FORM

Beacon Family Health · Toronto

CONFIDENTIAL · HIPAA PROTECTED

PATIENT INFORMATION

FULL NAME (LAST, FIRST, MI)

e.g. Doe, John A.

DATE OF BIRTH

GENDER

PHONE (MOBILE)

(416) 000-0000

EMAIL ADDRESS

name@example.com

STREET ADDRESS

123 Main Street, Apt #

POSTAL CODE

M5H 1A2

EMERGENCY CONTACT

CONTACT NAME

Full name

RELATIONSHIP TO PATIENT

PRIMARY PHONE

(416) 000-0000

ALTERNATE PHONE

(416) 000-0000

INSURANCE INFORMATION

INSURANCE PROVIDER

e.g. Sun Life / Manulife / Blue Cross

POLICY NUMBER

XXX-XXXX-XXXX

GROUP NUMBER

GRP-00000

POLICY HOLDER NAME

If different from patient

RELATIONSHIP TO PATIENT

MEDICAL HISTORY

Please check all conditions that apply, past or present:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Asthma
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Thyroid Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Migraines
- ☐ Arthritis
- ☐ Allergies (food/drug)

ALLERGIES

KNOWN ALLERGIES

List all known allergies (food, medication, environmental):

CURRENT MEDICATIONS

MEDICATIONS

List all medications, dosages, and frequencies:

REASON FOR VISIT

TODAY'S VISIT

Describe symptoms or reason for today's visit:

HIPAA CONSENT & AUTHORIZATION

> *I acknowledge receipt of Beacon Family Health's Notice of Privacy Practices and authorize the release of my protected health information (PHI) to healthcare providers, insurance carriers, and authorized representatives for treatment, payment, and healthcare operations under HIPAA. I may revoke this authorization in writing at any time, except where action has already been taken in reliance upon it.*

☐ I have read and agree to the terms above and consent to the use and disclosure of my health information as described.

DATE (MM / DD / YYYY)

X _____

Signature

PATIENT SIGNATURE (OR LEGAL GUARDIAN)