Weston Jane Medical Clinic
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PATIENT INTAKE FORM WALK-IN

First and Middle Name: _____ Last Name: _____

D.O.B. (M/D/Y) ____ / ____ / _____ Gender: M F Marital Status: _____

Address: _____ City: _____ Postal Code: _____

Cell Phone #: (_____) _____ Home Phone #: (_____) _____

Language(s) Spoken: _____

Occupation: _____ Employed at: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Cell Phone #: (_____) _____

Medical History:

Present Medical Conditions:	Diabetes	Stroke
Heart Condition	Asthma	Cancer
High Blood Pressure	Arthritis	Back Pain
Epilepsy / Seizures	Present Pregnancy	

Others: _____

Medications: _____

Allergies: _____

Surgeries: _____

I understand that at no time will the clinic tolerate any kind of abusive behaviour either in person or on phone to any staff or health care provider(s) of the clinic. I also understand that in case of abusive or intimidating behaviour by me, the clinic staff will take appropriate action including and not limited to calling police, restricting admission in the future, and/or taking legal action.

Signature: _____ (Guardian or Parent signature in case patient is a minor)

Name: _____ Date (M/D/Y) ____ / ____ / _____