Vanguard Medical Clinic

NEW PATIENT INFORMATION

Full Name: ____
(First) (Middle) (Last)

Health Care #: ______________ Date of birth: (dd/mm/yy):________ Gender: M / F Age: _____

Address:____

City:_______________ Prov: _______________ Postal Code:____________

Home Phone: ______________ Cell/Alternate: ______________ Email:_________________

How did you hear about us? (Check all that apply)

Community: Newsletter ( ) Magazine ( ) Co-op/Safeway (receipts) ( )

Flyer: Mailbox ( ) Door to door ( )

Roadside Advertisements: Boards ( ) Banners ( )

Online: Website ( ) Google maps ( )

Referral from family or friend ( )

Others (please specify): ____________________

Reminder Preference: SMS ( ) Voice Mail ( ) E-mail ( ) No Reminder ( )

PLEASE CHECK ONE OF THE FOLLOWING BELOW:

☐ I, ____________________________ hereby freely and voluntarily consent to **Dr. Pamela Odiegwu** being my primary family physician.

☐ I, ____________________________ hereby freely and voluntarily consent that I am a walk-in patient in this clinic. Following are the details of my family physician.

Family Physician Name:______________________

Clinic Name: ____________________________ Phone Number: ________________

☐ I do not have any family physician, and /or I am looking for a family physician.

This consent is given based on the verbal and written information provided and the understanding that I am medically and physically qualified. I am free to ask questions at anytime.
I have options to withdraw my consent at any time without incurring penalty or loss of benefits otherwise available, including medical care at the clinic.
My signature below indicates that I voluntarily agree to consent, and I authorize the use and disclosure of my information in connection with the Primary Health Care. I will receive a signed copy of the consent and authorization form.

____
Patient Signature

____
Date