New Patient Application

Dr Masood Dadras (Male)
Dr. Hussaina Abdallah (Female)
353 Lake Street
St. Catharines, ON L2N 7G4
905-397-3038 (Telephone)
833-490-1329 (Fax)

Please note:
Patient **must have** a valid Health Card

Last Name:_____First Name:_____

Middle Name: _____

Preferred name (if different from legal name):_____

Date of Birth: (YYYY/MM/DD): _____

OHIP #(Health Card) _____ Version Code(Two Letters)_____

Address (Street name & number): _____

PO Box:_____ City: _____ Province:_____

Postal Code:_____ Cell Phone: _____

Home Phone:_____ Work Phone:_____

E-mail: _____

Preferred contact: _____

Emergency Contact (Name): _____

(number)_____

Emergency Contact Relationship to you:_____

Marital Status: _____

Power Of Attorney (POA) for Health Care: _____

Preferred Language_____ Is a translator required? _____

Who is completing this application form?_____

Name of Previous Health Care Provider AND Pharmacy you go to

:_____

Immunization: Bring or attach a list of your immunizations to the office

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HEALTH HISTORY:

1. Current Health conditions:

_____
_____
_____
_____

2. History of Health Conditions/Surgeries:

_____
_____
_____
_____

3. Prescription Medications & dosages (please bring your medication list from your pharmacy):

_____
_____
_____
_____

4. Non Prescription Medications and dosages:

_____
_____
_____

5. Medication allergies and reactions:

_____
_____
_____

6. Non-medication allergies and reactions:

_____
_____
_____

7. Family Health History (relationship, diagnosis and age of onset):

_____
_____
_____
_____
_____

Health Habits

8. Smoking History: Current smoker_____ Past Smoker_____ Start date:_____
Quit date:_____

9.. Alcohol History: Current intake: _____,

drinks per week: _____

10. Exercise History: Do you exercise regularly_____

Hours per week_____

Type of exercise: _____

11.: Recreational Drug use: Current use name and dosage:

_____

Past use name and dosage:

_____

_____

Any Special Considerations or Comments:

_____

_____

_____

How did you hear about our clinic?

_____

Please note that any missed appointments will have a charge of $25 -

I have read and understand all of the above information

Print name: _____ Signature:_____ Date: (Y/M/D): _____

PATIENT EMAIL COMMUNICATION CONSENT FORM

RISKS OF USING EMAIL

This offers patients the opportunity to communicate by email. Sending patient information includes several risks of which the patient should be aware. The patient should not agree to communicate with patients/staff via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

• The privacy and security of email communication cannot be guaranteed. • Employers and online services may have a legal right to inspect and keep emails that pass through their system.

• Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read email once it has been sent.

• Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.

• Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the staff or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.

• Email is permanent. Even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or in cyberspace. • The use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.

• Email can be used as evidence in court.

CONDITIONS OF USING EMAIL

Staff will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, staff cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct of the physician. Thus, patients must consent to the use of email for patient communication.

Consent to the use of email includes agreement with the following conditions:

• Emails to the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff, billing personnel and other health care professionals on our team who are part of your care, will have access to those emails.

• Email communication is not an appropriate substitute for clinical examinations. The patient is responsible for following up physician/staff email and for scheduling appointments where warranted.

• The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physician will not discuss such matters over email.

• Lake Street Medical is not responsible for information loss due to technical failures.

• The patient will notify Lake Street Medical should there be any change in email address.

INSTRUCTIONS FOR COMMUNICATING BY EMAIL

• Inform the Lake Street Medical of any change in the patient's email address • Review the email to make sure it is clear and that all relevant information is provided before sending to Lake Street Medical staff.
• Inform the Lake Street Medical physician/staff that the patient received the email. • Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
• Withdraw consent only by email or written communication to Lake Street Medical staff.
• Should the patient require immediate assistance, or should the patient's condition appear serious or rapidly worsen, the patient should not rely on email. Rather, the patient should call his/her family doctor's office for consultation or appointment, visit the office or take other measures (such as calling an ambulance) as appropriate.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between Lake Street Medical physicians/staff and me, and consent to the conditions outlined herein, as well as any other instructions that the Lake Street Medical physician/staff may impose to communicate with patients by email. I acknowledge Lake Street Medical physician/
staff's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered**.**

I am at least 18 years of age and competent to contract on my own behalf.

Patient's Name: Patient Signature: Date:
Patient's Address:

Patient's email: Witness Signature: Date:

YES, I, , WISH TO RECEIVE EMAIL FROM MY LAKE STREET MEDICAL STAFF TERMS OUTLINED ABOVE. ***NOTE: IF WE DO NOT RECEIVE A SIGNED COPY OF THIS FORM, WE WILL NOT BE ABLE TO EMAIL YOU*.