**Peoples Medical Clinic**
**Dr. George Youssef**
7-22214 Dewdney Trunk Road
Maple Ridge, BC, V2X 0E6
peoplesmedicalclinic@gmail.com
Phone: 604-479-1604  Fax: 604-479-1563

# Patient Registration & Information Form

**First Name: _____**  **Care Card # _____**

**Last Name: _____**  **Date of Birth: _____**

**Title: Mr. Mrs. Miss. Ms. Other: _____**  **Marital Status: _____**

**Gender: Male Female Other: _____**

**Address: _____ City:_____ Postal Code: _____**

**Mobile Number _____ Home Number _____**

**Email Address: _____**

**Next of Kin:** *Best person for us to contact on your behalf in the case of an emergency*

**Name: _____**  **Relationship: _____**

**Phone: _____**

**Emergency Contact:** *(Must be different to Next of Kin)*

**Name: _____**  **Relationship: _____**

**Phone: _____**

**Preferred Pharmacy: _____**

**Phone: _____**  **Fax: _____**

**Current Medical Conditions:**

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.....

.....

**Current Medications** *(including over the counter medications, vitamin, and minerals):*

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.....

.....

**Allergies:**

.....

.....

**Past Operations:**

.....

.....

**Social & Lifestyle History:**

**Do you drink Alcohol?** ☐ **No** ☐ **Yes**

**How often do you drink alcohol?** ☐ **Daily** ☐**Weekly (4+ times/week)** ☐**Monthly**

**Do you smoke?** ☐ **No** ☐ **Yes** **How much per day? _____**

**Recreation Drugs:** ☐ **No** ☐ **Yes** **Drug Name: _____**

**Last PAP Smear date: _____** (female patients only)

**Last Mammogram date: _____** (female patients only)

# REQUEST FOR RELEASE OF MEDICAL RECORDS

**Date: ……..**

**Previous Doctor's Name: …….**

**Phone: ……**

**Fax Number: …….**

*(Please do not send double sided pages of medical records)*

**I hereby request that my medical records be released to:**

**Dr. George Youssef**

**Peoples Medical Clinic**

**7-22214 Dewdney Trunk Road, Maple Ridge, BC, V2X 0E6**

**Phone: 604-479-1604 Fax: 604-479-1563**

**Patient Name …….**

**Date of Birth ……..**

**Care Card # ……**

**Date …… Patient Signature …….**

# Office Policy

**Appointment Cancellations & Rescheduling**

We require a minimum of 24 hours' notice to cancel or reschedule an appointment.

Cancellations made with less than 24 hours' notice may be subject to a fee.

**No-Show Policy**

Failure to attend a scheduled appointment will result in a $25 no-show fee.

Repeated no-shows may affect your ability to book future appointments.

**Late Arrivals**

If you arrive more than 15 minutes late, your appointment may need to be rescheduled to accommodate other patients.

Verbal abuse, harassment, threats, or inappropriate language toward staff or other patients will not be tolerated. This includes yelling, insulting remarks, discriminatory language, or aggressive behavior.

By signing below, I acknowledge that I have read, understand, and agree to the above policies.

**Patient Name: _____**

**Signature: _____**

**Date: _____**