REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: .....

To: .....

Previous Family Doctor & Clinic Name

.....

Address

....

City **Phone** **Fax**

I hereby request that my medical records be released to:

Dr. Moussa
Peoples Medical Clinic
7-22214 Dewdney Trunk Rd, Maple Ridge V2X 0E6
Tel: 604-479-1604 Fax: 604-479-1563

....

Patient Name **Date of Birth**

.....

Address

....

City **Phone** **Personal Health No.**

....

Patient Signature **Date**

PEOPLES MEDICAL CLINIC
DR.M.MOUSSA

Patient Registration & Information Form

We are committed to providing our patients with the best care.
To do this, it is essential that your health record is kept up to date and accurate.
ALL patients are asked to complete the following.

Family Name:.....

Given Name.....

Preferred Name:.....

Date of Birth: .....

Title: Mr Mrs Miss Ms Dr Other.....

Address:.....

Postal Code:.....

Mobile No: .....

Home No:.....

Work No: .....

Email: .....

Health Care Card: ..... Exp: ...../.....

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:.....

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Current Medical conditions:

.....
.....
.....
.....

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

.....
.....
.....
.....

Do you have any **allergies** and / or are you **sensitive to any drugs** or **dressings**? Yes (please list) No

.....
.....
.....
.....

SOCIAL & LIFESTYLE HISTORY:

Alcohol: Non-drinker Drinker

How often do you have a drink containing alcohol: Never Monthly or less 2-4 times per month 2-4 times per week 4+times per week? .....

Smoking: No / Yes How much per day

Recreational drugs: No / Yes, Drug name:

.....

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PAST OPERATIONS

.....

.....

.....

FEMALES: When did you last have a:

Pap Smear: Date: ..... Not Sure / Never **FAMILY HISTORY:**

Please list any members of your family who have been diagnosed with, or suffered from: Diabetes / Hypertension / cancer / heart disease

Others:

.....

.....

N.B:

In order to help you better and avoid waiting time, in case of no show or cancellation less than 24 hours , there is a fee charge of 25$.

Patient's name: ..... **Date:** .....

Patient's signature: .....

Signed as Guardian for child: .....

Name: (printed) .....