



**HIGHBURY MEDICAL CLINIC**  
1345 Huron Street, Unit 4, London, Ontario, N5V 2E3  
Tel. 519-473-2464 Fax. 519-204-9294  
info@kamvamedical.ca

**Family Practice Roster Patient Intake & Consent Form**

**Clinic Information**

Clinic Name: Highbury Medical Clinic  
Clinic Address: 4-1345 Huron Street, London Ontario  
Phone: (519) 473-2464 Fax: (519) 204-9294

**Consent for Release of Medical Records**

I have chosen to attend the above physician as my primary care provider. I hereby give permission for the release of my pertinent medical records from my current or previous health care provider.

I understand that I am responsible for any fees charged by my previous provider for this service.

**Consent for Use of Medical Images and AI Documentation**

I consent to the use of clinical photographs taken during my medical care for documentation purposes in my medical chart. I also consent to the use of secure, AI-supported tools for medical note-taking, understanding that my information will be handled in accordance with privacy and confidentiality standards.

**Roster Agreement**

By signing below, you consent to being rostered to the above physician under the Ontario Health Insurance Plan (OHIP) Family Health Organization model. You agree to seek primary care from this clinic whenever possible.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Patient Information**

Full Legal Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F  Other

Health Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Pharmacy Details**

Preferred Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

**Current or Previous Family Physician/Specialist**

Family Physician (if any): \_\_\_\_\_

Specialists currently seen: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Medical History (Check all that apply)**

Cardiovascular / Endocrine:

Heart Disease    High Blood Pressure    Diabetes

Respiratory:

Asthma    COPD    Other Lung Disease: \_\_\_\_\_

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Gastrointestinal:

IBS    IBD    Other: \_\_\_\_\_

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Musculoskeletal / Pain:

Arthritis    Back Pain    Chronic Pain    Fibromyalgia    Other: \_\_\_\_\_

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Dermatologic:

Eczema    Psoriasis    Acne    Other Skin Condition: \_\_\_\_\_

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Neurological:

Seizures    Neuropathic Pain    Other: \_\_\_\_\_

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**Mental Health:**

Depression    Anxiety    PTSD    Bipolar Disorder    Other: \_\_\_\_\_

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**Medications & Allergies**

Current Prescription Medications (name, dose, frequency):

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Over-the-Counter / Herbal / Supplements:

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Medication Allergies Only (include reaction):

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Surgical / Hospitalization History

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**Social History**

Tobacco:  Never  Past  Current — Packs/day: \_\_\_\_\_ Years: \_\_\_\_\_

Alcohol:  Never  Occasionally  Regular — Drinks/week: \_\_\_\_\_

Substance Use:  None  Marijuana  CBD  Cocaine  Other: \_\_\_\_\_

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Frequency/Duration: \_\_\_\_\_

Health Needs & Concerns

- Diabetes  Hypertension  High Cholesterol
- Thyroid Disorder  Asthma/COPD
- Skin Conditions (e.g., eczema, acne, psoriasis, etc.)
- Chronic Pain  Addiction/Substance Use Disorder
- Mental Health Conditions (e.g., anxiety, depression)

Briefly describe your main health concern(s):

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**Family Health History**

Please list family history of health conditions like heart disease, cancer, diabetes, asthma, and mental illnesses?

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**Focus of Care**

Our clinic specializes in general family medicine with an interest in dermatology and preventive care.

Please indicate if you are seeking care for:

- Dermatological concern
- Routine primary care
- Ongoing chronic condition management
- Other (specify): \_\_\_\_\_

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**Patient Expectations**

What are your main goals in joining this practice?

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Do you anticipate requiring regular prescriptions for pain medication or controlled substances?

Yes  No

Do you currently have a pain management or addiction specialist?

Yes  No If yes, please provide name/contact: \_\_\_\_\_

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Do you currently have any limitations or circumstances that may affect your ability to work or attend appointments regularly?

Yes  No If yes, please specify the reason or program (e.g., ODSP, WSIB, etc.):

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Are there any programs, supports, or benefits (e.g., workplace, insurance, or government) currently assisting you with your health or daily functioning?

Yes  No If yes, please specify the reason or program:

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