KAMVA Medical

HIGHBURY MEDICAL CLINIC
1345 Huron Street, Unit 4, London, Ontario, N5V 2E3
Tel. 226-667-0627 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: (226) 667-0627 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: _____

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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: _____

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Medical History (Check all that apply)

Cardiovascular / Endocrine:

☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes

Respiratory:

☐ Asthma ☐ COPD ☐ Other Lung Disease: _____

_____

Gastrointestinal:

☐ IBS ☐ IBD ☐ Other: _____

_____

Musculoskeletal / Pain:

☐ Arthritis ☐ Back Pain ☐ Chronic Pain ☐ Fibromyalgia ☐ Other: _____

_____

_____

_____

Dermatologic:

☐ Eczema ☐ Psoriasis ☐ Acne ☐ Other Skin Condition: _____

_____

_____

Neurological:

☐ Seizures ☐ Neuropathic Pain ☐ Other: _____

_____

_____

Mental Health:

☐ Depression ☐ Anxiety ☐ PTSD ☐ Bipolar Disorder ☐ Other: _____

Medications & Allergies

Current Prescription Medications (name, dose, frequency):

Over-the-Counter / Herbal / Supplements:

Medication Allergies Only (include reaction):

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Surgical / Hospitalization History

_____

_____

_____

_____

_____

Social History

Tobacco: ☐ Never ☐ Past ☐ Current — Packs/day: _____ Years: _____

Alcohol: ☐ Never ☐ Occasionally ☐ Regular — Drinks/week: _____

Substance Use: ☐ None ☐ Marijuana ☐ CBD ☐ Cocaine ☐ Other: _____

_____

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?

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): _____

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: _____

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.):

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: