LAST NAME:	**FIRST NAME:**	
MSP CARE CARD / PHN NUMBER:	**DATE OF BIRTH:**	**SEX:** **M F X**
HOME ADDRESS:	**HOME NUMBER:**	
CITY & POSTAL CODE:	**WORK NUMBER:**	
EMAIL ADDRESS:	**MOBILE NUMBER:**	

EMERGENCY CONTACT NAME AND PHONE #:

MEDICAL HISTORY:	**SURGICAL HISTORY:**
ALLERGIES:	**FOR EYESIGHT, DO YOU USE:** □ Contact Lenses □ Glasses □ None of the Above □ Other:_____
VACCINATION HISTORY (INCLUDE DATES):	**FAMILY MEDICAL HISTORY:**

MOST RECENT PAP DATE:	**MOST RECENT MAMMOGRAM DATE:**
MEDICATIONS, VITAMINS, SUPPLEMENTS:	**DO YOU:** **Smoke Cigarettes?** □ Yes □ No **If Yes, How Many Per Day? _____** **Drink Alcohol?** □ Yes □ No **If Yes, How Many Per Week? _____**
REASON FOR SEEING THE DOCTOR:	**Use Recreational Drugs?** □ Yes □ No **If Yes, Specify: _____**

SECTION BELOW FOR OFFICE USE ONLY

HEIGHT:_____ WEIGHT:_____

HEAD CIRCUMFERENCE (INFANT <1 YEAR OLD ONLY): _____

BLOOD PRESSURE:_____ PULSE:_____

PATIENT AGREEMENT AND CONSENT

Pharmanet Access:
I authorize _____, or any designate within _____, to access my Pharmanet medication profile, health registry demographics, and diagnostic test history for the purpose of providing care and treatment.

Sharing Information for Continuity of Care:
I give consent for my information to be provided to other health care professionals, outside of this practice, to assist in my care.

Patient Responsibilities, No-Shows and Late Cancellation Policy:

- Patients are responsible for ensuring their contact information is up-to-date. This includes phone numbers, email addresses, and home/mailing addresses.
- I am aware that a full 24 hours notice is required for appointment cancellation.
- I understand that all missed appointments & late cancellations (*less than 24 hours notice*) are subject to a $50 fee.
- I understand that this fee is calculated per appointment, per patient.

Electronic Communication and Online Booking:

I understand that _____ utilizes Email and Text to communicate with patients. I give consent for my participation in Email and/or Text Communication, and Online Booking.

I understand that my email will be kept confidential, and will be used only for the purpose of medical office communication, reminders, appointment notifications, and delivery of requisitions. I consent that my email may be shared with other health care professionals outside of this practice, such as specialist's offices, to assist in my care. *(Many consultants and specialist offices require patient email addresses to be included with referrals so that they may contact patients directly)*

_____staff and physicians will use reasonable means to protect security and confidentiality of information sent/received. However, _____ physicians and staff cannot guarantee security and confidentiality of electronic communication. Many of the risks to consider are as follows:

- *Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.*
- *Despite reasonable efforts to protect the privacy and security of electronic communication, _____ cannot guarantee absolute security of the information.*
- *Employees of technology software companies and online services may have a legal right to inspect and keep electronic communications that pass through their systems.*
- *Electronic communications can be forwarded, intercepted, circulated, stored, or changed without the knowledge or permission of _____ physicians, staff, or patients.*
- *After the sender and recipient have deleted electronic communications back-up copies may still exist on another computer system.*
- *Electronic communications may be disclosed in accordance with a court order, or duty to report.*
- *Emails, text messages, and instant messages can more easily be misdirected. This may result in increased risk of being received by unattended and unknown recipients.*
- *Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies.*

I acknowledge and understand the risks, limitations, and conditions of use for electronic communication. I understand and accept the outline of risks associated with the use of electronic communications.

I acknowledge and understand that despite recommendations that encrypted software be used as a security measure for electronic communications, it is possible that communication services may not be encrypted. Despite this, I agree to communicate with _____ using these services with a full understanding of the risk.

I understand that I, or the physician, at any time, may withdraw the option of electronic communication.

_____	_____	_____
PATIENT NAME (PRINTED)	*SIGNATURE (Patient, Parent/Guardian, or Legal Representative)*	*DATE*

_____	_____
WITNESS SIGNATURE	*DATE*