

## PATIENT REGISTRATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS

**Patient's Name:** \_\_\_\_\_  

Last Name
First Name
Middle Names

**Preferred Name (if different):** \_\_\_\_\_

**Personal Health Care #:** \_\_\_\_\_ **Male / Female /** \_\_\_\_\_

**Date of Birth (yyyy/mm/dd):** \_\_\_\_\_ **Height:** \_\_\_\_\_ ft / cm **Weight:** \_\_\_\_\_ lb / kg  

Year
Month
Day

**Current Address:** \_\_\_\_\_  

City
Province
Postal Code

**Home Phone #:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_

**E-mail Address (if you consent to e-mail communications):** \_\_\_\_\_

**Family Doctor's Full Name:** \_\_\_\_\_ **Doctor's Phone #:** \_\_\_\_\_

**Local Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Preferred language if English is not spoken:** \_\_\_\_\_

**Religion (where medically relevant, such as Jehovah's Witness):** \_\_\_\_\_

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

<p><b>Allergies &amp; Reactions:</b></p> <p><b>Any Previous Surgeries:</b></p> <p><input type="checkbox"/> <i>Space is insufficient, a separate list is attached</i></p>	<p style="text-align: center;"><b>Current Medications &amp; Dosages:</b></p> <p><input type="checkbox"/> <i>Space is insufficient, a separate list is attached</i></p>
<p><b>Cigarettes/E-cigarettes:</b>    <input type="checkbox"/> Never</p> <p><input type="checkbox"/> I have smoked for ___ years and quit ___ years ago</p> <p><input type="checkbox"/> I have smoked for ___ years and currently smoke</p> <p><b>Alcoholic beverages:</b> _____ per week    <input type="checkbox"/> None</p> <p><b>Other substances:</b> _____    <input type="checkbox"/> None</p>	<p style="text-align: center;"><b>Pharmacy Information:</b></p> <p>Pharmacy Name:</p> <p>Address:</p> <p>Phone #:</p> <p>Fax #:</p>

I hereby authorize Dr. Liu Hennessey's office to request and/or release my medical records from and/or to

- Other physicians/specialists/nurses/health practitioner for continuing care purposes
- Medical facilities (Hospital/Residential Care Homes/Pharmacy/Laboratory, etc.)
- Legal Institutions (WorkSafeBC/ICBC/Law Firms/Court, etc.) *\*IF APPLICABLE\**

as required while under her care.

→ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_