DR. RACHEL LIU HENNESSEY, MD, MSC, FRCSC
General Surgery
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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 (mm/dd/yyyy): _____ _____ _____ **Height:** _____ ft / cm **Weight:** _____ lb / kg
Month Day Year

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 #:** _____

If English not spoken, languages spoken: _____

Religion (where medically relevant, such as Jehovah's Witness): _____

Occupation: _____

Allergies & Reactions:	**Current Medications & Dosages:**
	☐ *Space is insufficient, a separate list is attached*
Do you smoke cigarettes? ☐ Never ☐ I have smoked for ___ years and quit ___ years ago ☐ I have smoked for ___ years and currently smoke **I drink _____ alcoholic beverages per week**	**Pharmacy Information:** Pharmacy Name: Address: Phone #: Fax #:

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

- ☐ **Other Physicians/Specialists/Nurses (for continuing care purposes)**
- ☐ **Medical Facilities (Hospital/Residential Care Homes/Pharmacy/Laboratory, etc.)**
- ☐ **Legal Institutions **IF APPLICABLE** (WorkSafeBC/ICBC/Law Firms/Court, etc.)**

as required while under her care.

→ **Completion Date:** _____ **Patient's Signature:** _____