NICKMEDICAL CLINIC
180 Parsons Rd. Alliston ON, L9R 1E8
Ph: (705) 435-6500 Fx: 705-435-6501
www.nickmedical.com

Date: _____ Date of Birth: _____

Patient Name: _____

Address: _____

_____

Phone: _____

Dear Patient:

Please complete the form below to help us determine how to best serve you as a new patient. The doctor will review this form and if you are accepted as a patient, you will be contacted by our office within 10 days. If we do not contact you it means that the doctor is unable to accommodate you, and it is recommended that you look for another physician.

Any **misleading information can** lead to future termination of the doctor patient relationship.

1) What is the name and address of your current family Doctor?

2) What is the reason that you wish to move from your current family doctor to our clinic?

3) Current health conditions

4) List all medications you are currently taking

5) How did you find out about us?