CityMed
Your Partner in Health

4-1493 Foster St White Rock, BC V4B 0C4
Phone: (604) 385-1493

Medical Clinic

NEW PATIENT INTAKE FORM

Patient Information

Last Name : _____ Given Name : _____

PHN : _____ Province : _____

Demographic Information

Gender : _____ Age : _____

Date of Birth : _____ Sex Assigned at Birth and Pronouns : _____

Contact Information

Home Address : _____

Phone # : _____ E-mail : _____

Emergency Contact Name : _____ Phone # : _____

Secondary Phone : _____

Occupation

Occupation : _____ Work Phone : _____

Referral Information

Who referred you to us : _____

Do you consent to receive documents from this clinic via email? : ☐ Yes ☐ No ☐ Other: _____

Family Members

Will other family members join our clinic at the same time?* ☐ Yes ☐ No ☐ Other: _____

*If yes, please ask them to complete a separate intake form for each of them.

Current Family Physician (for possible transfer of records)?

Physician's Name : _____

Clinic Name and Address : _____

Phone and Fax number : _____

Medical History

☐ **Make CityMed Pharmacy as Default Pharmacy**

Current medical conditions

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

Thank you for completing this form.

4 _____ 9 _____
5 _____ 10 _____

Past medical conditions

1 _____ 6 _____
2 _____ 7 _____
3 _____ 8 _____
4 _____ 9 _____
5 _____ 10 _____

Surgical History
(Please provide details of any surgical procedures that you have undergone or plan to undergo)

1 _____ Place : _____ Year : _____
2 _____ Place : _____ Year : _____
3 _____ Place : _____ Year : _____
4 _____ Place : _____ Year : _____
5 _____ Place : _____ Year : _____

Allergies [Do you have any allergies to medications, food, or other substances? (Please specify or write "None"]

Medications Allergy : _____
Food Allergy : _____

Current Medications

1 Medication Name : _____ Dosage : _____
2 Medication Name : _____ Dosage : _____
3 Medication Name : _____ Dosage : _____
4 Medication Name : _____ Dosage : _____
5 Medication Name : _____ Dosage : _____

Additional Information
[Is there any other relevant information that you would like to add?]

_____
_____

Signature _____
Date _____

Thank you for completing this form.

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ELECTRONIC COMMUNICATIONS, INCLUDING EMAILS AND TEXT MESSAGES, AND TALI AI – PATIENT CONSENT FORM

TALI AI is an advanced, voice-enabled medical assistant designed to streamline clinical documentation, medical searches, and electronic health record (EHR) management. It helps physicians reduce administrative workload, allowing them to focus more on patient care.

I, **[ ]**, hereby consent to:

- My physician using TALI AI for documentation in accordance with the *TALI AI Information* document.
- The processing and retention of transcripts and notes related to my medical care.
- Receiving electronic communications, including emails and text messages, from CityMed Medical Clinic.

I acknowledge that my personal health information will be handled per the *Personal Information Protection Act (PIPA)* and applicable British Columbia privacy laws. I understand that I may revoke this consent in writing at any time.

Email:
Name:
DOB:

Signature: _____
Date: _____

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TRANSFER OF RECORDS REQUEST

Patient's name _____

Date of birth Health Card Number _____

Telephone Number _____

Name, address FAX number of previous doctor:

_____ _____

_____ _____

Specific Medical Records Requested For Transfer for The Past 3 Years.

I have chosen to attend Dr _____ as my practitioner. To provide continuity of care for myself, would you please forward all medical records for the past 3 years including specialist consults, labs ECG's imaging results. Kindly also include any other significant information such as colonoscopies, pathology reports other surgeries, regardless of timeline and older information if patient not seen within the last years. For female patients include last cytology/mammogram reports.

Transfer Method:

- USB
- Secure Email
- Secure Portal
- Mail

Patient Signature: _____ **Date:** _____

Please fill out the Healthrecord request form after becoming a patient at CityMed Medical Clinic. Thank you

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No-Show Policy

At CityMed Medical clinic- Whiterock, we strive to provide timely and efficient care to all our patients. To ensure that our services remain accessible, we have established the following **No-Show Policy**:

1. **Definition of a No-Show**
    a. A "No-Show" occurs when a patient misses a scheduled appointment without prior notice.
    b. Cancellations made less than 2 hours before the appointment time may also be considered a No-Show.
2. **Impact of No-Shows**
    a. Missed appointments prevent other patients from receiving care in a timely manner.
    b. Repeated No-Shows may disrupt clinic operations and availability for others.
3. **Consequences of No-Shows**
    a. First No-Show: A courtesy reminder of our policy.
    b. Second No-Show: A warning notice regarding future scheduling limitations.
    c. Third No-Show: Potential restrictions on future appointments, including prepayment requirements or limited scheduling availability.
4. **Cancellation and Rescheduling**
    a. Patients are encouraged to cancel or reschedule at least [2-3 hours] in advance.
    b. Cancellations can be made via [phone, email, or online portal].
5. **Exceptions**

- We understand that emergencies happen. Exceptions may be considered on a case-by-case basis.

Thank you for helping us maintain accessible and efficient healthcare services for all our patients!

Ministry of Health

PHARMANET
Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Schedule Act,* S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, _____, authorize _____
Name of Patient (print) *Name of Physician (print)*

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physician.

Executed at _____, this _____ day of _____, 20____.

SIGNED AND DELIVERED by)
)
)
_____)
Patient (print))
)
in the presence of:)
)
)
_____) _____
Witness (signature)) *Patient (signature)*
)
_____)
Witness (print))
)
_____)
(Dated))