General Medical History

The information requested below will assist in the practitioner treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law; your written permission will be requested to release any information.

Personal History

Title: ○ Dr. ○ Mr. ○ Mrs. ○ Ms. Date:_____

Name: _____/_____ Birthday: _____
Surname First name DD/MM/Year

Address: _____ Phone(Home): _____

City: _____ Province: _____ Phone(Cell): _____

Postal Code: _____ Email: _____

Reason for today's visit: _____

Western Medical Diagnosis: _____

Family Physician: _____

How did you hear about this Clinic: __ social media
__ internet search
__ friend or family/ name:_____
__ yellowpages
__ other _____

Emergency Contact:_____ Phone:_____

Alberta Health Care Number:_____

Do you have insurance?:_____ Name of company:_____

***In the event your insurance carrier does not pay for treatment provided to you, you will be responsible for payment. Please initial _____

East Meets West Health Centre would like your permission to contact you by email for appointment reminders, promotional offers, etc. You will be able to unsubscribe at any time.

- ☐ Yes, I'd love to receive email reminders, etc.
- ☐ No, I don't want email reminders, etc. at this time.