Coppersmith
Medical Clinic

New Patient Application Form

Last Name: _____ First Name: _____

Date of birth: DD _____ MM _____YYYY_____ Gender _____

Provincial Health Number: _____Province: _____

Street Address: _____

City: _____ Postal Code: _____

If patient is a child or under 18 years of age:

Parent/Guardian Name (1): _____

Parent/Guardian Name (2): _____

Best Contact Phone Number: _____ (cell / home / work)

Alternate Contact Phone Number: _____ (cell / home / work)

Email Address (***please read and sign Email Consent Form on page 2***):

_____

Emergency Contact Person (Name, Relationship): _____

Emergency Contact Phone Number: _____ (cell / home / work)

Current or previous family doctor's contact information:

Name: _____

Address: _____

Phone: _____Fax: _____

Pharmacy contact information:

_____

Please mail completed forms to:
Coppersmith Medical Clinic, 305 - 11331 Coppersmith Way, Richmond BC, V7A 5J9

Coppersmith
Medical Clinic

Email Consent Form

By providing us with your email address you have consented to our use of the contact information.

What we use your email for:

- Your family doctor may send you forms and requisitions for medical tests by email; the documents sent by your family doctor's office will be password protected
- We may share your email information with medical specialists' office when you are referred to a medical specialist for care

Your responsibility:
You are responsible for informing us should:

- Your email contact change
- Should you choose to no longer receive email communication from us
- Should you choose to not provide your email to a medical specialist or clinic that you are being referred to

Our responsibility:

- We will only share your email with other health care providers directly involved with your care
- To protect your personal health information, we will not respond to requests for medical appointments by email, we will not discuss medical issues or health information by email

Risks of using electronic communication
We cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system, within and outside of Canada
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient
- Due to the sensitivity of the information, we recommend that you do not use a shared email

Name of Patient: _____

Signature: _____

Date: _____

Please mail completed forms to:
Coppersmith Medical Clinic, 305 - 11331 Coppersmith Way, Richmond BC, V7A 5J9

Coppersmith
Medical Clinic

Patient Name:

Brief Medical History

If you require more space in any of the sections, please attach a separate page

Current/ongoing medical conditions (e.g. high blood pressure, diabetes, depression, etc.):

_____

_____

Previous/resolved medical conditions (e.g. childhood asthma, eczema, broken wrist, etc.):

_____

_____

Surgeries/procedures or hospitalizations (please include the year and details of any time you had surgery, or were admitted to the hospital overnight):

_____

_____

Prescription medications (include name of medication, dose/strength, and how often you take it, e.g. Lipitor 10 mg once per day, ramipril 5 mg two times per day):

_____

_____

Over the counter and herbal products:

_____

Allergies (include the trigger and the reaction you get, e.g. penicillin - rash, peanuts - hives):

_____

Smoking History: [ ] Current Smoker - Number of cigarettes per day _____
[ ] Previous smoker [ ] Never smoked

Alcohol History: Number of drinks/week: _____

Name and contact information of medical specialists involved in your care:

_____

Please mail completed forms to:
Coppersmith Medical Clinic, 305 - 11331 Coppersmith Way, Richmond BC, V7A 5J9

Family medical history (please indicate family member and age at diagnosis):

Heart disease, heart attack: [ ] NO [ ] YES

Family member and age at diagnosis: _____

Stroke: [ ] NO [ ] YES

Family member and age at diagnosis: _____

High blood pressure: [ ] NO [ ] YES

Family member and age at diagnosis: _____

Diabetes: [ ] NO [ ] YES

Family member and age at diagnosis: _____

Cancer: [ ] NO [ ] YES

Family member and age at diagnosis: _____

Other:

_____

Children (please list gender, age, and any serious illness):

_____

_____

Relationship status: _____

Current occupation: _____

Please mail completed forms to:
Coppersmith Medical Clinic, 305 - 11331 Coppersmith Way, Richmond BC, V7A 5J9

Ministry of Health

MEDICAL PRACTICE
ACCESS TO PHARMANET AGREEMENT

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))
)
_____)
Witness (print))
)
_____)
(Dated))

_____
Patient (signature)

Please mail completed forms to:
Coppersmith Medical Clinic, 305 - 11331 Coppersmith Way, Richmond BC, V7A 5J9