Dr. Behzad Hassani HBA MD CCFP(EM) FCFP CMCBT
Ms. Mahsa Haghighi MD RN MN NP-PHC
Phone: (519) 673 3900 Fax: (519) 673 5627
Unit 1 – 1261 Beaverbrook Avenue
London, ON, N6H 4L1
EMAIL: hassanioffice@beaverbrookmedical.ca

NEW PATIENT APPLICATION FORM

Dr. Hassani and NP Haghighi have partnered together in a shared practice model to be the new primary care providers to one patient roster. As such, please be advised that requests for preferential scheduling with a specific healthcare provider will not be accommodated in our practice. Exceptions may be granted on a discretionary basis.

Thank you for taking the time to fill out this application. Completion of this form does not guarantee registration at our clinic. Once the completed form has been submitted, received, and accepted, our front desk staff will contact you to arrange your first appointment. Please be thoughtful and complete the application in its entirety. Incomplete applications will be rejected. By completing this application, you provide consent for Dr. Hassani to access and review your personal health history. Please write N/A if a question is not applicable to you.

Last Name: _____

First Name:_____Preferred Name:_____

Health Card Number (including version code): _____

Health Card Expiry Date (yyyy/mm/dd): _____

Date of Birth (yyyy/mm/dd): _____

Sex (M/F/Other): _____ Preferred Pronoun: _____

Home Address: _____

Preferred Phone number: _____

Emergency Contact (Name, Relationship, Number): _____

Previous Family Physician's Name: _____

Previous Family Physician's Phone Number: _____

Previous Family Physician's Fax Number: _____

Preferred Pharmacy Name and Address: _____

Preferred Pharmacy's Phone number: _____

Reason for changing Doctor: _____

Allergies (Please include the name of medication or food, type of reaction, and age of onset):

Medication allergies: _____

Food allergies: _____

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Medical History

Please list the CONFIRMED medical or mental health problems that you have been diagnosed with by a health care professional, if any. Write N/A if you do not have confirmed diagnosis.

Diagnosis	Year of Diagnosis	Name of Specialist (if any)

Do you have any NEW problems or health concerns that have not been addressed? Write N/A if none. _____

_____

Surgeries & Procedures

Please list any surgeries/procedures you have had in the past, including any miscarriages, abortions, or caesarean sections. Write N/A if none.

Surgery	Date (dd/mm/yy)	Where	Name of Surgeon

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Medication List

Please list any current medications that you are taking, including prescription medications, over-the-counter medications, and supplements. Write N/A if none. **Please bring ALL your medications/supplements on your first visit. If you are on MORE THAN 3 medications, please have your pharmacist fax us a "Medication Check".**

Medication Name	Dosage	Frequency	Year started

Preventative Screening

Please note that the following applies to certain age groups, gender, and risk factors.

Screening test	The most recent Test (mm/yy)	Result (Normal or abnormal)
Pap Smear		
Fecal Immunochemical Test (Stool Test for Blood)		
Mammogram		
Colonoscopy		
Bone Mineral Density		

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Immunizations

Please note that some immunizations are given to people of certain age groups and risk factors. Some of these questions may not apply to you. **For children up to the age of 18, please enclose all the immunizations as a copy of their immunization record.**

When was your last tetanus shot (every 10 years)? _____

Have you had HPV vaccine? (e.g. Gardasil)? ☐ No ☐ Yes, When? _____

Do you get the annual flu shot? ☐ No ☐ Yes

Have you had a pneumonia shot (for over 65 years old)? ☐ No ☐ Yes, When? _____

Have you had a shingles shot? ☐ No ☐ Yes, When? _____

Social and Lifestyle History

What is your occupation? _____

What Languages do you speak? _____

Do you require a translator? ☐ No ☐ Yes

Alcohol use: Do you drink alcohol? ☐ No ☐ Yes

Current (drinks/week) _____ Past (drinks/week) _____

Cigarettes: Have you smoked cigarettes? ☐ No ☐ Yes

Current (cigs/day): _____ Past (cigs/day): _____ # of Years: _____

Recreational Drug Use? ☐ No ☐ Yes, if yes, please provide detail per use:

_____

Do you have any other substance use concerns past or present? ☐ No ☐ Yes, please provide details: _____

Are you on ODSP, OW, Trillium Coverage? If yes, which one? _____

Patient Name **Patient Signature** (Please print and sign) **Date**

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PATIENT DISCLAIMER

Family Practice Patient Commitment

I agree to contact my family doctor, (or if applicable the group to which my family doctor belongs or the designated Telephone Health Advisory Service if available to me, when I, or my enrolled child(ren) or dependent adult(s), need primary care medical service or treatment. I promise to do this unless there is an emergency, or I am travelling away from home.

I agree that if I or the person(s) I have signed for relocate, I will contact my family doctor's office or the ministry with a new address and telephone number.

I understand that I can end my enrolment with this family doctor and enroll with another family doctor after six weeks have passed from the date that I have been accepted as a new patient in this practice (or immediately if I have moved). However, I agree not to change the doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him/her/them to confirm enrolment/consent with the family doctor.

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Cancellation Conditions

Enrolment with my family doctor and my consent to release personal health information will STOP when:

- I cancel my enrolment by writing my family doctor or by writing or phoning the ministry.
- I no longer qualify for health care services under the Health Insurance Act (Ontario).
- The patient enrolment model to which my doctor belongs no longer exists.
- My family doctor chooses to discontinue acting as my family doctor in accordance with CPSO guidelines.
- I enroll with another family doctor, or the ministry grants me an extended absence.

My enrolment with my family doctor and my consent to release personal health information CAN end when:

- I consistently fail to meet the obligations to which I agreed in the Patient Commitment section (above), and as detailed in the document "Dr. Hassani's Patient Policies", a copy of which will be provided to you on the day of your first appointment.
- My family doctor leaves this Patient Enrolment Model.
- I become a resident of a long-term facility.
- I am imprisoned in a provincial or federal correctional institutions.
- I move outside the geographic area where my family doctor's Patient Enrolment Model regularly provides services.

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Zero Tolerance Policy

We take all incidents of aggressive, violent, or abusive treatment of our staff very seriously.

We recognize that our employees and medical practitioners have the right to safe and respectful work environment. In our interactions with you, we strive to ensure that you are treated with fairness, integrity, and respect.

We recognize that navigating the healthcare system can be challenging, and that the nature of circumstances can be very emotional. We understand that individuals may at times express themselves in less-than-ideal manner. Nevertheless, we will not tolerate profanity, insult, accusations, and disrespectful behavior. Violent, abusive, or aggressive behavior is grounds for immediate dismissal from the practice and includes but is not limited to the following:

- Using Profane language or swearing at team members.
- Verbal abuse towards the medical team in any form including verbally insulting and yelling.
- Racist, sexist, xenophobic, and discriminatory remarks.
- Persistent or unrealistic demands that create undue stress for the staff.
- Physical violence towards any team member or patient.
- Causing damage or stealing from our premises, staff, or patients.

The policy extends to any interaction with a staff member whether in-person, letter, by phone, email, or through our secure messaging service.

A breach of "Zero Tolerance Policy" constitutes grounds for immediate dismissal from our practice.

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Patient Consent

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION

I understand that in order to provide appropriate care, my family doctor will need to share appropriate and relevant information relating to my health with the "Ministry of Health".

I agree to allow my family doctor, other family doctors in the Patient Enrolment Model (if applicable) and the ministry to exchange health information in this form related to my enrolment. I agree that my family doctor and the ministry can exchange information about my name, address, and telephone number. I agree to allow the ministry to release the following information to my family doctor:

- Dates of immunizations (flu shots, etc)
- Dates of preventative care screening services (pap tests, mammograms…)
- Dates of service, fee paid, and fee codes of primary health care services provided to me by a family doctor outside my family doctor's Patient Enrolment Model. (if applicable)

If the "Telephone Health Advisory Service" is available to me, I agree to allow my family doctor and the ministry to exchange only the following information with the designated "Telephone Health Advisory Service": my name, health card number and version code, address, date of birth, and gender.

I understand that this consent to release personal health information ends when:

- My enrolment with my family doctor ends
- I cancel my consent by writing or telephoning the "Ministry of Health and Long-Term Care".
- The ministry informs my family doctor when the consent is no longer valid. However, I understand that the information already released to my family doctor will remain in my medical file.

I have read and agree to "Patient Commitment, Cancellation Conditions, Zero Tolerance Policy, and the Consent to Release Personal Health Information" as detailed above.

I acknowledge that this enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligation between my family doctor and me.

First & Last Name **Patient Signature** **Date**

(Please print and sign)