Registration Form

Name: _____

Address: _____

Province: _____ Postal Code: _____

Health Card No.: _____ Version Code: _____

Date of Birth (MM/DD/YYYY): _____ Sex: _____

Cell Phone No.: _____ Alternate No.: _____

Email: _____

Emergency Contact Name: _____ Emergency Contact No.: _____

Referring Doctor: _____ Family Doctor: _____

PRESENT PROBLEM:

(Purpose of your visit today): _____

Location on your body: _____ How long have you had this condition: _____

Treatment(s) to date: _____

Other associated symptoms: _____

PAST MEDICAL HISTORY: Do you have any of the below conditions or surgeries? Please circle.

Asthma *Hayfever* *Diabetes* *Liver Disease* *High Blood Pressure*

Cancer *BCC* *SCC* *Melanoma* *Kidney Disease* *Pacemaker*

Artificial Joint *Artificial Heart Valve* *Other:* _____

MEDICATIONS Do you have any prescriptions, over-the-counter or herbal medications? If you have a list please provide it to the receptionist.

_____

Are you allergic to any medications? If yes, please list: _____

Do you have to take antibiotics before you go to the dentist? _____

Would you be interested in participating in a research study? If yes, please provide your email address: _____

Occupation: _____ Hobbies: _____

FAMILY HISTORY: Are there any diseases that run in your family? (Please Circle) Yes No

If yes, please list: _____

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Do you or any of your blood relatives have the following conditions? (please circle and indicate relationship):

Skin Cancer? _____ Skin Melanoma? _____ Eczema? _____

Psoriasis? _____

Do you smoke? Yes No Do you drink alcoholic beverages on a regular basis? Yes No

REVIEW OF SYSTEMS: Do you have any current or past problems with any of the following? Please circle.

General Health	*Eyes*	*Liver*	*Ears/Nose/Throat/Mouth*
Heart	*Lungs*	*Stomach/Bowel*	*Headaches/Seizures*
Blood/Bleeding Disorder	*Psychological Disorder*	*Thyroid/Diabetes*	*Joints/Arthritis*

If you circled any of the above, please describe: _____

Are you pregnant? Yes No Are you planning to become pregnant? Yes No

We offer several cosmetic services such as: Sclerotherapy, Botox, Fillers, Lasers, Chemical Peels, etc. If you are interested or any further questions, please speak with a receptionist.

Our Privacy Commitment Summary

The Lynde Institute for Dermatology collects, uses and discloses your personal information in compliance with the requirements of the Personal Health Information Protection Act (PHIPA). Your name, contact information, medical history and billing information as well as any charts, examination results and other health information collected or produced while we provide you with health care services will form part of your personal health information file.

Personal Information is collected and shared for the purpose of:

- providing information to those involved in the provision of your health care
- obtaining reimbursement from OHIP or third party payers for our services
- in the administration of our clinic

Our staff is required to keep your personal information confidential. Your personal information will not be used for any other reason without your consent

I consent to the use of my personal information as stated above and authorize the Lynde Institute for Dermatology the ability to release medical information concerning my visit to the referring physicians.

Print Patient Name	Patient/Guardian Signature	Date (MM/DD/YYYY)

Dr. Francesca Cheung, Dr. Anne Goodfellow and Dr. Sanja Knezevic are Family Physicians who have limited their practice to diseases of the skin, hair, and nails. They both hold a “Focused Practice Designation in Dermatology” from the Ontario Medical Association recognized by the Ontario Ministry of Health and Long-Term Care.