Seneca Health Centre

HEALTH REGISTRATION FORM

PATIENT INFORMATION				
Title: Miss Ms. Mrs. Mr. (circle one)	Last Name	Fist Name	Preferred Name:	
Address:				
City:		Postal Code:	(residence is M2J 5G3)	
Phone numbers where you can be reached:	Home	( )	Voicemail: Yes No	
	Cell	( )	Voicemail: Yes No	
	Work	( )	Voicemail: Yes No	
May we leave a detailed message on any of these numbers? Yes No ****no personal information will be left **** Please specify: ☐ Home ☐ Cell ☐ Work				
Personal Email:		Seneca Email:		
Date of Birth: Y Y Y Y / M M / D D		Gender (circle one): Male Female		
Health Card #: # # # # / # # # / # # #		Version: __ __ (Ontario only) Indicate here if out of province: _____		
Are you a ☐ domestic or ☐ international student?		Seneca ID #: # # # / # # # / # # #		

IN CASE OF EMERGENCY		
Name of local friend or relative: (not living at same address)		Relationship:
Address:		
City:	Postal Code:	Phone #:
Family Physician:		Phone #:
Address:		
City:	Postal Code:	Fax #:

Please Turn Over →

HEALTH INFORMATION

Allergies: _____

Do you use an epi-pen? Yes No (circle one)

Present or Past Illness(es)	**Yes**	**No**	**Comments**
Diabetes			
Epilepsy			
Asthma			
Heart Disease			
High Blood Pressure			
Headaches			
Cancer			
History of: Muscle / Bone injuries			
Mental Health Issues (incl. anxiety, depression)			
Infectious Disease (e.g. Hepatitis C)			
Weight Loss or Gain (unexplained)			
Hospitalizations (in the past year)			
Presently Describe:			
Birth Control Use			
Alcohol/Drug Use (if yes, please indicate amount/frequency)			
Sleeping well?			
Do you smoke? (if yes, please incl. how often, since when)			

Do you take any medication? (Please list each drug by name including drugs for birth control, smoking cessation, epilepsy, blood pressure, etc):

_____

The information submitted on this form is true to the best of my knowledge. I understand the information contained herein is **confidential**. It is intended for use by the Seneca Health Centre staff only in the event that I require their services. I further understand that this information will **NOT** be released to anyone outside the Health Centre without my written permission.

_____ _____

Student's signature Date

Freedom of Information and Protection Privacy Act 1987. The information on this form is collected under the legal authority of the College and Universities Act, R.S.O. 1980. C272, SS; Regulated Health professions Act 1991, S. 36(1) for the use of the Health Centre Staff.