**OAKRIDGE PEDIATRICS PATIENT INTAKE FORM**

Ages: Newborn to 18 years

**Please complete all relevant sections**

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| **Name:** | **Date of Birth:** | | **Personal Health Number:** |
| **Address:** | **City:** | | **Postal Code:** |
| **Family Doctor:** | **School:** | | **Pharmacy:** |
| **Child Lives with:**  □Mother □Father □Step Parent/Family □Siblings & Ages:  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Name of Parent (Mother)/Guardian:** | | **Phone:**  **Email:** | |
| **Name of Parent (Father)/Guardian:** | | **Phone:**  **Email:** | |

|  |  |
| --- | --- |
| **Appointment Notice Reminder:** (please indicate one)  **□** Text to cell phone □ Email □ Voicemail to home | **Preferred Contact:**  **(Name)** |

|  |
| --- |
| **Labour and Delivery**  Where (Hospital):  Brief History:  Complications/Concerns: |
| **Child’s Allergies** (include date noted if known)**:** |
| **Child’s Medications** (include dose if known): |
| **Health concern(s) to be addressed at appointment:** |
| **Past relevant hospitalizations:** |
| **Relevant health concern(s)** (family history): |