NIAGARA NORTH Family Health Team

Please note:
Patient **must have** a valid OHIP Card
Patient **cannot** have a Family doctor

Nurse Practitioner Lead Clinic
318 Ontario Street, St. Catharines, ON,

New Patient Application 2024

Demographic Data:

Last Name:_____First Name:_____Middle Initial: _____

Preferred name (if different from legal name):_____

Date of Birth: (YYYY/MM/DD): _____ OHIP # _____

Address (Street name & number): _____ PO Box:_____

City: _____ Province:_____ Postal Code:_____

Cell Phone: _____ Home Phone:_____ Work Phone:_____

E-mail: _____ Preferred contact: _____

Emergency Contact (Name): _____ (number)_____

Emergency Contact Relationship to you:_____

Marital Status: _____

POA for Health Care: _____

Preferred Language_____ Is a translator required? _____

Who is completing this application form?_____

Name of Previous Health Care Provider:_____

Immunization: Bring or attach a list of your immunizations to the office

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Health History:

1. Current Health conditions: _____

_____

_____

2. History of Health Conditions/Surgeries: _____

_____

_____

_____

3. Prescription Medications & dosages:_____

_____

_____

_____

_____

4. Non Prescription Medications and dosages:_____

_____

_____

5. Medication allergies and reactions:_____

_____

_____

6. Non-medication allergies and reactions: _____

_____

_____

_____

7. Medication coverage: _____

8. Family Health History (relationship, diagnosis and age of onset):_____

_____

_____

_____

Health Habits

9. Smoking History:

Current smoker_____ Past Smoker_____ Start date:_____Quit date:_____

10. Alcohol History

Current intake: _____, # drinks per week: _____

11. Exercise History

Do you exercise regularly_____ Hours per week_____

Type of exercise:_____

12: Recreational Drug use

Current use name and dosage: _____

Past use name and dosage:_____

_____

Any Special Considerations or Comments:

_____

_____

I have read and understand all of the above information

Print name: _____ Signature:_____ Date: (Y/M/D): _____

NIAGARA NORTH Family Health Team

Health Equity Questionnaire

We Ask Because We Care

At the Niagara North Family Health Team, we strive to provide the best health care possible for each of our patients. It has become know that some groups are at a disadvantage in our health care system, and we are striving to tackle this!

Our health care team has been gathering data to improve the quality of our programs and initiatives by specifically tailoring them to address your specific needs.

Please take a few minutes to answer the below questions.
This is **optional**. You do not need to answer any or all of these questions.
Please place a ✓ or a ✗ in the corresponding boxes.
Your answers will be treated with the same **confidentiality as the rest of your medical records**

What is your gender?

(cisgender describes a person whose gender identity is the same as their sex assigned at birth)

- ☐ Female (cisgender)
- ☐ Female (transgender)
- ☐ Gender non-conforming
- ☐ Genderqueer
- ☐ Intersex
- ☐ Male (cisgender)
- ☐ Male (transgender)
- ☐ Non-binary
- ☐ Two-Spirit
- ☐ More than 1 gender
- ☐ Questioning
- ☐ Other
- ☐ Prefer not to say

Comments _____

What are your pronouns ?

☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ Other ☐ Prefer not to answer

Comments _____

What is your sexual orientation?

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Pansexual
- ☐ Polysexual
- ☐ Queer
- ☐ Questioning
- ☐ More than 1
- ☐ Other
- ☐ Prefer not to answer

Comments _____

What languages do you speak ?
(can pick more than one)

- ☐ Amharic
- ☐ Arabic
- ☐ ASL
- ☐ Bengali
- ☐ Cantonese
- ☐ Mandarin
- ☐ Czech
- ☐ Dari
- ☐ English
- ☐ Farsi
- ☐ French
- ☐ Greek
- ☐ Hindi
- ☐ Hungarian
- ☐ Indigenous
- ☐ Italian
- ☐ Karen
- ☐ Korean
- ☐ Mandarin
- ☐ Nepali
- ☐ Polish
- ☐ Portuguese
- ☐ Punjabi
- ☐ Russian
- ☐ Serbian
- ☐ Slovak
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Tamil
- ☐ Tigrinya
- ☐ Turkish
- ☐ Twi
- ☐ Ukrainian
- ☐ Urdu
- ☐ Other (please specify)

_____

Comments

_____

What is your racial background ?
(can pick more than one)

- ☐ Afghan
- ☐ Africain
- ☐ African
- ☐ Canadian
- ☐ Afro-Caribbean
- ☐ Kurdish
- ☐ Lebanese
- ☐ Pakistani
- ☐ Arab
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Persian
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Egyptian
- ☐ European
- ☐ Filipino
- ☐ Indian
- ☐ Thai
- ☐ Turkish
- ☐ Vietnamese
- ☐ Indigenous Inuit
- ☐ Indigenous Metis
- ☐ Indigenous Other
- ☐ Indo-Caribbean
- ☐ Indonesian
- ☐ Iranian
- ☐ Japanese
- ☐ Korean
- ☐ Other
- ☐ Do not know
- ☐ Prefer not to answer

Comments _____

What is your combined annual household income ?

- ☐ $14,999 and below
- ☐ $15,000 to $19,999
- ☐ $20,000 to $24,999
- ☐ $25,000 to $29,999
- ☐ $30,000 to $34,999
- ☐ $35,000 to $39,999
- ☐ $40,000 to $59,999
- ☐ $60,000 to $89,999
- ☐ $90,000 to $119,999
- ☐ $120,000 to $149,999
- ☐ $150,000 and above
- ☐ Other
- ☐ Do not know
- ☐ Prefer not to answer

Comments _____

Knowing more about you can help us provide you with the care that you need, the way that you need it.

Thank you for taking the time to help us improve your health care!

NIAGARA NORTH Family Health Team

318 Ontario Street , St. Catharines ON L2R 1R5 Tel: 343-213-0360 Fax: 905-684-6161

NIAGARA NORTH FAMILY HEALT TEAM
PATIENT EMAIL COMMUNICATION CONSENT FORM

RISKS OF USING EMAIL

The Niagara North Family Health Team (NNFHT) offers patients the opportunity to communicate by email. Sending patient information includes several risks of which the patient should be aware. The patient should not agree to communicate with NNFHT patients/staff via email without understanding and accepting these risks.
The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the NNFHT staff or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is permanent. Even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or in cyberspace.
- The use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.

CONDITIONS OF USING EMAIL

NNFHT staff will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, NNFHT staff cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct of the physician. Thus, patients must consent to the use of email for patient communication.
Consent to the use of email includes agreement with the following conditions:

- Emails to the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff, billing personnel and other health care professionals on our team who are part of your care, will have access to those emails.
- Email communication is not an appropriate substitute for clinical examinations.

The patient is responsible for following up on NNFHT physician/staff email and for scheduling appointments where warranted.

- Given that patient emails are being used as a ONE-WAY mode of communication at the present time (i.e. FROM the NNFHT to the patient), the patient, under no circumstances, should expect a response to any email sent to the NNFHT or its physicians/staff.
- The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physician will not discuss such matters over email.
- NNFHT is not responsible for information loss due to technical failures.
- The patient will notify NNFHT should there be any change in email address.

INSTRUCTIONS FOR COMMUNICATING BY EMAIL

To communicate by email, the patient shall:

- Limit or avoid using an employer's computer.
- Inform the NNFHT of any change in the patient's email address
- Review the email to make sure it is clear and that all relevant information is provided before sending to NNFHT staff.
- Inform the NNFHT physician/staff that the patient received the email.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to NNFHT staff.
- Should the patient require immediate assistance, or should the patient's condition appear serious or rapidly worsen, the patient should not rely on email. Rather, the patient should call his/her family doctor's office for consultation or appointment, visit the office or take other measures (such as calling an ambulance) as appropriate.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between NNFHT physicians/staff and me, and consent to the conditions outlined herein, as well as any other instructions that the NNFHT physician/staff may impose to communicate with patients by email. I acknowledge NNFHT physician/staff's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered**. I am at least 18 years of age and competent to contract on my own behalf.**

Patient's Name: _____

Patient's Address: _____

Patient's email: _____

YES, I, _____, WISH TO RECEIVE EMAIL FROM MY NURSE PRACTITIONER AND THE NIAGARA NORTH FAMILY HEALTH TEAMIN THE

TERMS OUTLINED ABOVE. ***NOTE: IF WE DO NOT RECEIVE A SIGNED COPY OF THIS FORM, WE WILL NOT BE ABLE TO EMAIL YOU*.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____