EAGLESMED

EAGLESMED WELLNESS CENTRE

Empowerment - Passion - Commitment - Innovation

PATIENT QUESTIONNAIRE

1. **Name (as it appears on Health Care Card)**
   First: _____
   Middle: _____
   Last: _____
   Preferred Name: _____

2. **Gender M F**

3. **Date of Birth**
   Day / Month / Year
   _____

4. **Contact Information**
   Home Phone: _____
   Mobile Phone: _____
   Work Phone: _____
   Address:
   Appt.(_____) _____
   City: _____ **Province:** _____ **Postal Code:**_____

5. **Health Care Number:**
   _____
   For out of province please indicate which province
   _____

6. **Emergency Contact**
   Name: _____ **Phone:** _____
   Name: _____ **Phone:** _____

7. **Additional people in patient's household wishing to be seen at Eaglesmed.**
   First Name: _____ **Last Name:** _____ **Gender: M F**
   Date of Birth(D/M/Y)_____ **Health Care Number:** _____

   First Name: _____ **Last Name:** _____ **Gender: M F**
   Date of Birth(D/M/Y)_____ **Health Care Number:** _____

   First Name: _____ **Last Name:** _____ **Gender: M F**
   Date of Birth(D/M/Y)_____ **Health Care Number:** _____

   First Name: _____ **Last Name:** _____ **Gender: M F**
   Date of Birth (D/M/Y)_____ **Health Care Number:** _____

8. **Present Family Physician:** _____

Name: _____ **Signature:** _____
Date: _____

Please print, fill out, and fax your completed questionnaire to 404-723-2463. Alternatively questionnaires can be dropped off at Eaglesmed Clinic Avenida.
As Eaglesmed is receiving considerable interest in family practice your request will be placed in a queue and you will be contracted by an Eaglesmed Team Member to book a "meet and greet" appointment with a physician.