**Seneca Medical Centre**

**HEALTH REGISTRATION FORM - INTERNATIONAL**

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| **PATIENT INFORMATION**  |
| Title: (circle one) Miss Ms. Mrs. Mr. N/A  | Last Name:  | First 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 Prefer not to say  |
| Seneca ID #: # # # **/**  # # # **/** # # #  |   |
| **IN CASE OF EMERGENCY**  |
| Name of local friend or relative: (preferably not living at same address)  | Relationship:  |
| Address:  |
| City:  | Postal Code:  | Phone #:  |
| **ALLERGY INFORMATION**  |
| Do you have any allergies? Yes No (circle one) If yes: Do you use an epi-pen? Yes No (circle one)  Please list allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |

 Please Turn Over

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| **HEALTH INFORMATION**  |
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|  **Present or Past Illness(es)**  | **Yes**  | **No**  | **Comments**  |
| Diabetes  |   |   |   |
| Epilepsy  |   |   |   |
| Asthma  |   |   |   |
| Heart Disease  |   |   |   |
| High Blood Pressure  |   |   |   |
| Headaches  |   |   |   |
| Any previous diagnosis or medical conditions (ex. cancer, syndromes) |   |   |   |
| 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 Medical 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 Medical Centre without my written permission.   Patient’s signature Date Freedom of Information and Protection Privacy Act 1987. The information on this form is collected under the legal authority R.S.O. 1980. C272, SS; Regulated Health professions Act 1991, S. 36(1) for the use of the Health Centre Staff. of the College and Universities Act,  |

Seneca Medical Centre ￭ 1750 Finch Avenue East, North York, Ontario, M2J 2X5 ￭ P: (416) 491-5050 x22965 ￭ F: (416) 493-8319 Rev. Dec. 13/18

**Seneca Medical Centre**

# INTERNATIONAL PATIENT JURISDICTION DECLARATION AND AGREEMENT

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|  |  | **PATIENT INFORMATION**  |  |
| Title: Miss Ms. Mrs. Mr. (circle one)  | Last Name  |  | First Name  | Date of Birth: **Y Y Y Y /M M / D D**  |
| Address:  |  |  |  |
| City:  |  |  | Postal Code:  | (residence is M2J 5G3)  |
|   |  |  |  |
|  |  | **AGREEMENT**  |  |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby agree that the relationship between myself, **Seneca Medical Centre**, as well as its agents, delegates, employees and any physicians and other independent health care practitioners providing medical or other health care and treatment to me at or in association with **Seneca Medical Centre** including any issues related to this Agreement, shall be governed by and construed in accordance with the laws of the Province of Ontario.

I hereby acknowledge that any treatment I receive will be performed in the Province of Ontario and that the courts of the Province of Ontario shall have exclusive jurisdiction to entertain any complaint, demand, claim or cause of action whatsoever arising between myself, **Seneca Medical Centre**, as well as its agents, delegates, employees and any physicians and other independent health care practitioners providing medical or other health care and treatment to me.

I hereby agree that if I, or anyone acting on my behalf, commence any such legal proceedings, I will do so only in the Province of Ontario, and hereby irrevocably submit to the exclusive and preferential jurisdiction of the Courts of the Province of Ontario.

 Student ID #

Patient’s signature Print Name Date

Witness’ signature Print Name Date

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