Assistant Clinical Professor of Medicine,
McMaster University

Specialist In Clinical Hypertension (ASH)
American Board of Internal Medicine Diplomate
American Board of Nuclear Cardiology Diplomate
Fellow of The Royal College of Physicians of Canada

**Please bring completed forms, health card and medications with you to your Appointment.**

# Alfi Moris Beshay, MD, MSc, FRCP(C)

**Internal Medicine & Cardiovascular Disease**

## PATIENT REGISTRATION FORM

(Please Print)

### Patient Information

Name: _____ Date: _____
Last First Middle Month Day Year

Address: _____

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

Fax No.: _____ Email: _____

Birth Date: _____Age_____ Gender: ☐ M ☐ F
Month Day Year

Religion (Optional): _____ Race (Optional): _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer / School _____Occupation: _____

Family Doctor_____ Phone: _____

Pharmacy_____ Phone: _____

Name of person to call in case of emergency _____ Relation: _____

Address_____Phone: _____

### Insurance Information

Are you covered by OHIP? ☐ Yes ☐ No OHIP No.: _____

Are you covered by other Insurance plans? ☐ Yes ☐ No Insurer: _____ Insurance ID#_____

Do other provinces Health plans cover you? ☐ Yes ☐ No Province: _____ Insurance ID#_____

**PS:** If you are not insured by any insurance plan please read and sign the financial statement in the second page of this form.

### Other Information

Have you assigned anyone Durable power of Attorney for your medical care? ☐ Yes ☐ No If yes, please fill in

Durable power of attorney Name: _____ Relationship: _____

Address: _____ Phone: _____

Do you have a medical Living Will? ☐ Yes ☐ No

**PS:** If you have any of these documents, please bring an up-to-date copy to be kept in your chart.

**Alfi Moris Beshay, MD, MSc, FRCP(C)**
**Internal Medicine & Cardiovascular Disease**

## NON –INSURED PATIENT STATEMENT

I understand that I am responsible for the cost of my medical treatment and I agree to pay at the time services are provided.

_____ _____
Date Signature

## CONSENT TO TREAT

I request and give consent to my physician to provide and perform such medical care, tests, drugs, and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me. This consent shall remain valid until revoked by me in writing. A copy of this consent shall be considered as valid as the original.

_____ _____
Date Signature

## RELEASE OF MEDICAL INFORMATION

I authorize my physician to release information from my medical record to my family physician and to my insurance carriers, or government agency for the processing of claims for medical benefits. This authorization shall remain valid until revoked by me in writing. A copy of this release shall be considered as valid as the original.

_____ _____
Date Signature

## UNINSURED SERVICE STATMENT

Dear Patient:

The Ontario Health Insurance Plan (OHIP) covers most of your medical needs. According to Section 24 of Regulation 552 of Revised Regulations of Ontario, 1990 under the *Health Insurance Act*, effective January 1, 1993; the following services rendered by physicians or practitioners are not insured services:

1. Toll charges for long distance telephone calls or faxes.
2. Advice given by telephone to an insured person at the request of the person or the person's representative.
3. An interview or case conference in respect of an insured person that lasts more those 20 minutes with a professional none of whose services are insured services.
4. The preparation and transfer of an insured person's health records when this is done because the care of the person is being transferred at the request of the person or the person's representative.
5. The providing of a prescription to an insured person if the person or the person's personal representative requests the prescription and no concomitant insured service is provided.
6. A missed appointment or procedure if less than 24 hours of notice of cancellation has been given by the patient.
7. Completion of different forms and reports for school, works, camps, fitness clubs, Canada Pension Plan (CPP), insurance certificates, and other life and health insurance report files…. etc.

I ACKNOWLEDGE that I am responsible for the cost of the medical services that are not covered by OHIP and I agree to pay at the time services are provided.

_____ _____
Date Signature

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

_____ _____
Date Print Name

_____
Signature