GREY MEDICAL CLINIC

Dr. Joshua Imonitie

Family Practitioner & Medical Educator

#106-22722 Lougheed Highway
Maple Ridge, BC, V2X 2V6
Phone: 604-463-4165
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NEW PATIENT APPLICATION FORM — COMMENCING AUGUST 2026

Important Notice: Dr. Joshua Imonitie is commencing his practice at the Grey Medical Clinic in **August 2026**. You can return this completed form via email to **drjoshua.greymedical@outlook.com** or in person directly to the surgery front desk. You are also welcome to contact us by email to schedule an introductory "meet and greet" appointment in August 2026.

1. REGISTRATION PREFERENCES & DISCOVERY

How did you hear about us? ☐ Friend/Family ☐ Direct Doctor Referral ☐ Community/Advert ☐ Other

Comments: _____

2. PERSONAL INFORMATION

First Name:		**Middle Name:**	
Last Name:		**Preferred Name:**	
Maiden Name:		**Date of Birth:**	DD / MM / YYYY
Gender Identity:	☐ M ☐ F ☐ Other	*** PHN (CareCard):**	
Street Address:			
City:		**Postal Code:**	
Home Phone:		**Cell Phone:**	
Email Address:			
Emergency Contact:		**Contact Relationship:**	
Contact Phone:			

Patient Name: _____ DOB: _____

3. TAILORED CARE & BOOKING PREFERENCES

Dr. Imonitie's practice model incorporates digital-first options and specialized pathways to better serve the community. Please indicate if any of the following apply to your family's healthcare goals:

☐ **Commuter & Busy Professional Access (Evening Virtual Clinic)**
I am interested in using the dedicated, 100% virtual late-evening clinic slots for telephone/video consultations after business hours.

☐ **Chronic Disease Management Integration**
I manage one or more chronic conditions (e.g., Diabetes, Hypertension, Asthma) and require ongoing, coordinated check-ups and planning.

☐ **Comprehensive Senior & Elderly Care**
The applicant is a senior citizen and/or requires specialized geriatric screening, polypharmacy reviews, and functional mobility monitoring.

☐ **Flexible Appointment Models (Please tick all that interest you)**
☐ Same-Day urgent openings ☐ Routine pre-bookable bookings ☐ Virtual/Telephone care options

4. MEDICAL HISTORY & PREFERENCES

Preferred Pharmacy Name/ Loc:		**Preferred Diagnostic Lab:**	
Previous Family Physician:		**Previous Doctor Clinic/City:**	
Active WorkSafeBC (WCB) Claim?	☐ Yes ☐ No	**Active ICBC Claim?**	☐ Yes ☐ No

5. PRESENT HEALTH & LIFESTYLE INDICATORS

Current Height:		**Current Weight:**	
Known Drug/Food Allergies:			
Current Active Diagnoses:			
Ongoing Symptoms of Note:			
Current Medications (Rx):			
Supplements / Non-Rx:			
Surgical History & Dates:			
Tobacco Use History:			

☐ Never Smoked ☐ Active Smoker ☐ Former Smoker (Quit Date: _____)

Weekly Alcohol Intake: _____ **Other Substance Use?** ☐ Yes ☐ No

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SUBMISSION PROCESS & APPLICANT AGREEMENT

6. SUBMISSION & CONTACT INSTRUCTIONS

Please read carefully before submitting:

- **One form per person:** Each family member must complete an individual application form.
- **Complete forms only:** Ensure all sections (particularly PHN/CareCard number) are fully completed.
- **Submission Methods:** Unlike standard clinic procedures, you may submit this form in **two convenient ways**:
  - **By Secure Email:** Send your scanned PDF form to **drjoshua.greymedical@outlook.com**
  - **In Person:** Drop off the physical form at the front desk of the **Grey Medical Clinic** (Open 9am–5pm, Monday to Friday).
- **Meet & Greet:** You are welcome to email **drjoshua.greymedical@outlook.com** directly to schedule your initial "Meet and Greet" appointment commencing in **August 2026**.

7. TERMS, DISCLAIMER & CATCHMENT INFORMATION

Please note that submitting this application form does not guarantee automatic acceptance or establish a formal doctor-patient relationship. Applications are reviewed systematically to ensure clinic capacity and alignment of scope.

Clinical Intake Parameters:

1. Applications may be declined if the patient holds an active, local family practitioner still in active practice.
2. Non-residents of Canada or those living outside the geographical catchment area may not be eligible.
3. Medical concerns must align with the physician's clinical scope and professional capacity limits.
4. **DO NOT** request your medical records from your previous clinic until after your initial Meet & Greet appointment and confirmation of acceptance is finalized.

8. PATIENT DECLARATION & SIGNATURE

By signing below, I certify that the personal and medical information provided in this document is accurate, honest, and true to the best of my knowledge. I understand that any incomplete or dishonest information may result in the immediate cancellation of my application.

Applicant Signature: _____ **Date:** _____

For Office Use Only — Date Received: ____ / ____ / _____ | Processed By: _____ | Status: Approved / Deferred