Ontario Ministry of Health

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Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen.

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Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*
Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery
City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township
City/Town | Postal Code
or ☐ same as mailing address

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery
City/Town | Postal Code
or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township
City/Town | Postal Code
or ☐ same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery
City/Town | Postal Code
or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township
City/Town | Postal Code
or ☐ same as Section 1

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 – Family doctor information

PG14771
DR. GARY TRAN
WESTEND FAMILYCARE CLINIC FHO

BILLING NO. 043294 GROUP NO. BALT

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

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