

Patient Enrolment and Consent to Release Personal Health Information

One form per adult patient. Photocopy for additional adult family members.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

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	Mailing Address	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery	
Date of Birth (yyyy/mm/dd)	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town		Postal Code
Send notices from my family doctor's office to me by: <input type="checkbox"/> regular mail <input type="checkbox"/> email (if possible)		Residence Address	Apartment #	Street No. and Name or Lot, Concession and Township	
Email Address:			City/Town		Postal Code
		<input type="checkbox"/> 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	Mailing Address	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery	
Date of Birth (yyyy/mm/dd)	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town		Postal Code
I am this person's <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney for personal care		Residence Address	Apartment #	Street No. and Name or Lot, Concession and Township	
			City/Town		Postal Code
		<input type="checkbox"/> or same as Section 1			

B Last Name		First Name		Second Name	
Health Number	Version Code	Mailing Address	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery	
Date of Birth (yyyy/mm/dd)	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town		Postal Code
I am this person's <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney for personal care		Residence Address	Apartment #	Street No. and Name or Lot, Concession and Township	
			City/Town		Postal Code
		<input type="checkbox"/> 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 Date (yyyy/mm/dd)

X

Home Telephone No. () Work Telephone No. () Family Doctor's Signature **X** Date (yyyy/mm/dd)

Section 4 Family doctor information

Dr. JENNIFER MCALISTER
FINDLAY FHO

BILLING NO: 045416 GROUP NO: BATQ

Primary Health Care New Patient Declaration

Do not mail this form to the ministry. This form must remain in the physician's office for audit purposes.

Please complete this form if you are a new patient of a primary care physician and have signed a Patient Enrolment and Consent to Release Personal Health Information form. If you are signing on behalf of a child or dependent adult, and have completed a Patient Enrolment and Consent to Release Personal Health Information form on their behalf, complete the applicable sections below.

Declaration

I am signing on behalf of (check the applicable boxes)

- myself (complete sections A and C)
- the children listed below of whom I am the parent or guardian (complete sections B and C)
- the dependent adult (s) listed below for whom I have a power of attorney for personal care (complete sections B and C)

I hereby declare that the patient(s) named below does/do not have a family physician due to one or more of the following circumstances: (check applicable boxes)

- The patient's family physician has moved to another community.
- The patient has moved to another community.
- The patient's physician is no longer available due to illness/death/retirement.
- The patient's physician is no longer available due to change of practice type.
- Up until now the patient has not had, or felt the need for a family physician.

Section A: Patient Information

First Name	Last Name	Health Number
------------	-----------	---------------

Section B: Children and Dependent Adults

1. First Name	Last Name	Health Number
---------------	-----------	---------------

2. First Name	Last Name	Health Number
---------------	-----------	---------------

For additional children / dependent adults, please complete another New Patient Declaration form.

Section C: Signature and Date

Signature	Date <i>yyyy/mm/dd</i>
-----------	---------------------------

Section D: Physician Signature and Date

I declare that the above patient is not presently a patient of mine or, to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable). I also declare that no child listed (if any) is a newborn of any existing enrolled or non-enrolled patient of mine, or to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable).

I agree to accept the above-noted patient(s) into my practice and to provide ongoing health care to the patient(s) from the date of this document. I will keep this document available on file in my primary office location and will provide copies to the Ministry of Health as required for verification purposes.

Physician Last Name (print) MCALISTER	First Name (print) JENNIFER
--	--------------------------------

Physician Signature	Date <i>yyyy/mm/dd</i>
---------------------	---------------------------