

Patient Enrolment and Consent to Release Personal Health Information

Microfilm use only

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	Mailing Address ▶	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery
Date of Birth (yyyy/mm/dd)		Sex ☐ M ☐ F		City/Town	
Send notices from my family doctor's office to me by: ☐ regular mail ☐ email (if possible)			Residence Address ▶ ☐ or same as mailing address	Apartment #	Street No. and Name or Lot, Concession and Township
Email Address:				City/Town	Postal Code

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 ▶ ☐ or same as Section 1	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery
Date of Birth (yyyy/mm/dd)		Sex ☐ M ☐ F		City/Town	
I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care			Residence Address ▶ ☐ or same as Section 1	Apartment #	Street No. and Name or Lot, Concession and Township
				City/Town	Postal Code

B Last Name		First Name		Second Name	
Health Number		Version Code	Mailing Address ▶ ☐ or same as Section 1	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery
Date of Birth (yyyy/mm/dd)		Sex ☐ M ☐ F		City/Town	
I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care			Residence Address ▶ ☐ or same as Section 1	Apartment #	Street No. and Name or Lot, Concession and Township
				City/Town	Postal Code

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.

()

Section 4 – Family doctor information

PG14856
DR. JASON KLEMENSBERG
OTTER CREEK FHO
303- 343 WILSON AVE
TORONTO, ON M3H1T1

BILLING NO. 043333 GROUP NO. BAPX

(Include Billing no. and Group no.)

Family Doctor's Signature

X

Date (yyyy/mm/dd)