

Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen.

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 ☐ M ☐ F		City/Town	
Send notices from my family doctor's office to me by: ☐ regular mail ☐ email (if possible)			Residence Address	Apartment #	Street No. and Name or Lot, Concession and Township
Email Address:				City/Town	
			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

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	
I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care			Residence Address	Apartment #	Street No. and Name or Lot, Concession and Township
				City/Town	
			or same as Section 1 ☐		

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	
I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care			Residence Address	Apartment #	Street No. and Name or Lot, Concession and Township
				City/Town	
			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.
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Section 4 – Family doctor information

PG07731
DR. ANITA GREIG
OTTER CREEK FHO

BILLING NO. 030387 GROUP NO. BAPX

(Include Billing no. and Group no.)

Family Doctor's Signature Date (yyyy/mm/dd)
X