

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

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

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Section 4 – Family doctor information

PG07729
DR. SARA COHEN-GELFAND
OTTER CREEK FHO

BILLING NO. 025617 GROUP NO. BAPX

(Include Billing no. and Group no.)

Family Doctor's Signature

Date (yyyy/mm/dd)

X