WINDSOR
Family | Health | Team

PATIENT ENROLMENT DATA

All data collected is for the purpose of providing you with patient services. This data will not be shared with any person not employed by the Windsor Family Health Team without your consent.

Last Name _____ First Name _____ Initial _____

Date of Birth _____

Biological Gender: ❒ Female ❒ Male ❒ Other _____

Additional Optional Details: (If you prefer to verbally disclose this information to your primary care provider please feel free to do so.)

Gender Identity: ❒ Female ❒ Male ❒ Other _____
Sexual Identity: ❒ LGBT ❒ Heterosexual ❒ Other _____

Health Card Number _____ Version Code_____ Expiration_____

Street Address _____

_____

City _____ Postal Code _____

Home Phone _____ Cell Phone _____

Work Phone: _____ Email _____

Emergency Contact _____ Relationship _____

Phone _____

Former Family Physician _____

Pharmacy_____

Location_____

How did you hear about the Windsor Family Health Team?

- ❒ Radio
- ❒ Newspaper
- ❒ TV
- ❒ Brochure/ pamphlet
- ❒ Online
- ❒ Friend/ family/ co-worker
- ❒ Other: _____

Personal Medical History - Please check all that apply (current and past):

Condition	Current	Past (date)	Details
Migraines			
Difficulty Breathing			
Sinus Problems			
Dental Problems			
Eye Problems			
High Blood Pressure			
High Cholesterol			
Heart Disease			
Bleeding Problem			
Thyroid Problem			
Diabetes			
Breathing Problem			
Heartburn			
Irritable Bowel Syndrome			
Kidney Problems			
Difficulty Passing Urine			
Chronic Pain			
Muscle Problems			
Arthritis			
Prostate Problems			
Cancer			
Depressions			

Anxiety			
Bipolar Disorder			
Seizures			
Alcoholism/Drug Abuse			
Skin Problem			
Other			

LIFESTYLE:

Do you smoke? Yes ❒ NO ❒ If yes, how many per day? _____

Do you drink alcohol? Yes ❒ No ❒ If yes, how many drinks per week? _____

Do you use recreational drugs? (marijuana, cocaine, ecstasy, etc) Yes ❒ No ❒

Gambling: Have you played Lotteries, Bingo, Sports Betting, Slots etc. in the past 1 year?
Yes ❒ No ❒
If yes, please consider the following gambling research study – participation is optional:

1. Have you ever tried to stop, cut down or control your gambling? **YES ❒ NO ❒**
2. Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences, or planning out future gambling ventures or bets? **YES ❒ NO ❒**
3. Have you ever lied to family members, friends or others about how much you gamble or how much money you lost on gambling? **YES ❒ NO ❒**

HOSPITAL ADMISSIONS (Please list the Hospital, year, and reason for admission)

_____

_____

_____

SURGERIES (Locations, Date, what procedure):

_____

_____

_____

_____

MEDICATIONS (If the name is unknown, please list what the medication is for)

1	6
2	7
3	8
4	9
5	10

MEDICATION ALLERGIES: Yes ❒ No ❒ If yes, please fill in below:

1- _____ Reaction: _____
2- _____ Reaction: _____
3- _____ Reaction: _____

ENVIRONMENTAL ALLERGIES / REACTIONS:

Family History

Please check the following health issues that your <u>FAMILY MEMBERS</u> have:

Condition	Relationship/Details	Year (approx)
Bleeding Problem		
Asthma		
Severe Arthritis		
Alcoholism		
Cancer		
Diabetes		
Seizures		
Glaucoma		
High Blood Pressure		
High Cholesterol		
Heart Attack		
Stroke		
Migraine Headaches		
Osteoporosis		
Skin Disease		
Thyroid Disease		

Genetic Disease		
Depression		
Other Mental Illness		
Other (list)		
Other (list)		

Family Member Enrolment

Please list family members under15 years of age that you would like to have enrolled

Last Name ______________________ First Name ______________ Initial ____

Date of Birth_________________ Gender: Female ❒ Male ❒ Other ____________

Relationship to you: ____

Health Card number ________________ Version Code ______ Expiration _______

Last Name ______________________ First Name ______________ Initial ____

Date of Birth_________________ Gender: Female ❒ Male ❒ Other ____________

Relationship to you: ____

Health Card number ________________ Version Code ______ Expiration _______

Last Name ______________________ First Name ______________ Initial ____

Date of Birth_________________ Gender: Female ❒ Male ❒ Other ____________

Relationship to you: ____

Health Card number ________________ Version Code ______ Expiration _______

Last Name ______________________ First Name ______________ Initial ____

Date of Birth_________________ Gender: Female ❒ Male ❒ Other ____________

Relationship to you: ____

Health Card number ________________ Version Code ______ Expiration _______

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

	First Name	Last Name	Health Number
1.			
2.			

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

Section C: Signature and Date

Signature	Date

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 and Long-Term Care as required for verification purposes.

Physician Last Name *(print)*	First Name *(print)*

Physician Signature	Date

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Microfilm use only / Réservé aux microfilms

Health Number/Numéro de carte Santé | Versi

Ministry Use Only/Réservé au ministère

Health Number Release

Divulgation du numéro de carte Santé

This form may be submitted to the Ministry of Health and Long-Term Care when the Health Number of a patient is not available

La présente formule peut être envoyée au ministère de la Santé et des Soins de longue durée lorsque le numéro de carte San d'un patient ou d'une patiente n'est pas disponible.

Confidential when completed/Renseignements confidentie

1. Patient/Patiente

A. General Information/Renseignements généraux

Last name/Nom de famille

First name/Prénom

Middle name/Deuxième prénom

Sex/Sexe ☐ M ☐ F

Birth date/Date de naissance year/année month/mois day/jour

If an alternate last name is known, please provide/Si vous avez un deuxième nom de famille, inscrivez ici

B. Health Number Disclosure/Divulgation du numéro de carte Santé

The Ministry of Health and Long-Term Care will give your Health Number to the health care provider/facility.

I agree to allow the Ministry of Health and Long-Term Care to release my Health Number to the health care provider/facility listed below.

Le ministère de la Santé et des Soins de longue durée donnera votre numéro de carte Santé au fournisseur/à la fournisseuse ou à l'établissement de soins de sant

J'autorise le ministère de la Santé et des Soins de longue durée à divulguer mon numéro de carte Santé au fournisseur ou à l'établissement de soins de santé dont le nom figure ci-dessous.

Collection of the information on this form is for the assessment and verification of eligibility for Health Insurance and Drug Benefit and administration of the Health Insurance and Ontario Drug Benefit Acts, and fo health planning and coordination. It is collected/used for these purposes under the authority of the Ministry of Health Act, section 6(1,2), Health Insurance Act, section 4(2) (b,f), 10, 11(1), and Regulation 201/96 under the Ontario Drug Benefit Act, section 2. For information about collection practices, call 1 800 268-1154, in Toronto (416) 314-5518, or write to the Director, Registration and Claims Branch, P.O. Box 48, 49 Place d'Armes, Kingston ON K7L 5J3.

Les renseignements demandés dans cette formule sont réunis aux fins d'évaluation et de vérification de l'admissibilité à l'assurance-santé et aux prestations de médicaments gratuits, aux fins d'administration de *Loi sur l'assurance-santé* et de la *Loi de 1986 sur le régime de médicaments gratuits de l'Ontario*, et aux fins de planification et de coordination ces services de santé. Ces renseignements sont réunis ou utilisés ces fins en vertu de la *Loi sur le ministère de la Santé*, paragraphes 6(1),(2), de la *Loi sur l'assurance-santé*, alinéas 4(2)b),f), article 10, paragraphe 11(1), et du Règlement 201/96 pris en application de la *Loi de 1986 sur le régime de médicaments gratuits de l'Ontario*, paragraphe 2. Pour plus de précisions sur la collecte de ces renseignements, faites le 1 800 268-1154 ou, à Toronto, le (416) 314-5518, ou écrivez au directeur ou à la directrice de l'inscription et des demandes de règlement, C.P. 48, 49, Place d'Armes, Kingston ON K7L 5J3.

Signature of ☐ applicant ☐ legal guardian ☐ parent ☐ power of attorney X

Date

Home phone number / Téléphone (domicile) ( )

Business phone number / Téléphone (bureau) ( )

A parent or guardian may sign for a child under 16 years of age. An attorney under continuing power of attorney, an attorney under power o personal care, or a legal guardian may also sign on behalf of an individual of any age.

Le père, la mère ou le tuteur, la tutrice peuvent signer pour un enfant de moins de 16 ans.

2. Provider/Facility / Fournisseur/Fournisseuse/Établissement

Provider no./N° du fournisseur

Provider's phone number
N° de téléphone du fournisseur ( )

Facility no./N° de l'établissement

Facility phone number
N° de téléphone de l'établissement ( ) –

The Health Number of the patient will be returned to the provider/facility listed here.

Le numéro de carte Santé du patient/de la patiente sera transmis au fournisseur/à la fournisseuse/à l'établissement de soins de santé dont le nom figure ci-dessous.

Date of service/Date de prestation du service
year/année month/mois day/jour

Provider/Facility name and address/Nom et adresse du fournisseur

Ministry Use Only/Réservé au ministère

Date received

Date processed

Processed by