

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 <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.

()

Section 4 – Family doctor information

PG10230
DR. GARWAY WONG
THORNHILL VILLAGE FHO
18 CENTRE STREET
THORNHILL, ON L4J1E9

BILLING NO. 024831 GROUP NO. BADW

(Include Billing no. and Group no.)

Family Doctor's Signature

X

Date (yyyy/mm/dd)