

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	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 or same as mailing address <input type="checkbox"/>	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 <input type="checkbox"/>	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 or same as Section 1 <input type="checkbox"/>	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 <input type="checkbox"/>	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 or same as Section 1 <input type="checkbox"/>	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 X Date (yyyy/mm/dd)

Home Telephone No. () Work Telephone No. ()

Section 4 – Family doctor information

PG15436
 DR. MEAGAN THANG
 THORNHILL VILLAGE FHO

BILLING NO. 047685 GROUP NO. BADW

(Include Billing no. and Group no.)

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