Ontario Ministry of Health

Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen

Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name: Pooh
First Name: Winnie
Second Name: T.
Health Number: X XX X X X X X X X
Version Code: X X
Date of Birth (yyyy mm dd): 1924 04 22
Sex: [X] M [ ] F
Send notices from my family doctor's office to me by: [ ] regular mail [ ] email (if possible)
Email Address:

Mailing Address ▶
Apartment # / Street No. and Name or P.O. Box, Rural Route, General Delivery: 100 Acre Wood North
City/Town: Clarksburg, ON
Postal Code: N0H 1J0

Residence Address ▶
Apartment # / Street No. and Name or Lot, Concession and Township:
City/Town:
Postal Code:
or [X] 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: Pooh
First Name: piglet
Second Name: M.
Health Number: X X X X X X X X X X
Version Code: X X
Date of Birth (yyyy mm dd): 1940 09 17
Sex: [X] M [ ] F
I am this person's: [X] parent [ ] legal guardian [ ] attorney for personal care

Mailing Address ▶ or [ ] same as Section 1
Apartment # / Street No. and Name or P.O. Box, Rural Route, General Delivery: 100 Acre Wood North
City/Town: Clarksburg, ON
Postal Code: N0H 1J0

Residence Address ▶ or [ ] same as Section 1
Apartment # / Street No. and Name or Lot, Concession and Township:
City/Town:
Postal Code:

Last Name: Pooh
First Name: Tigger
Second Name: R.
Health Number: X X X X X X X X X X
Version Code: X X
Date of Birth (yyyy mm dd): 1938 06 10
Sex: [X] M [ ] F
I am this person's: [X] parent [ ] legal guardian [ ] attorney for personal care

Mailing Address ▶ or [ ] same as Section 1
Apartment # / Street No. and Name or P.O. Box, Rural Route, General Delivery: 100 Acre Wood North
City/Town: Clarksburg, ON
Postal Code: N0H 1J0

Residence Address ▶ or [ ] same as Section 1
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): [X] myself [X] child(ren) [ ] dependent adult(s)

My Name: Winnie T. Pooh
Signature: x Winnie Pooh
Date (yyyy/mm/dd): 2021/05/01
Home Telephone No: ( )
Work Telephone No: ( )

Section 4 – Family doctor information

PG14742
DR. KARA FAUSER
GEORGIAN BAY FHO
186 MARSH ST
CLARKSBURG, ON N0H1J0

BILLING NO. 039423 GROUP NO. BAHN

(Include Billing no. and Group no.)

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

Queen's Printer for Ontario, 2006

PHYSICIAN COPY

Ontario Ministry of Health

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)*

- X Myself (complete sections A and C)
- ☐ The child(ren) 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
- X The patients 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
Winnie	Pooh	XXXX XXXXX

Section B: Children and Dependent Adults

	First Name	Last Name	Health Number
1	Piglet	Pooh	XXX XXXX
2	Tigger	Pooh	XXX XXXX

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

Section C: Signature and Date

Signature: Winnie Pooh

Date: May 1, 2021

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), and I declare that the 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)
FAUSER	KARA

Physician Signature	Date

© Queen's Printer for Ontario, 2005