Ontario Ministry of Health

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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

Date of Birth *(yyyy/mm/dd)* | Sex ☐ 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 | City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

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

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

or ☐ same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

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
X

Date *(yyyy/mm/dd)*

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)*

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