TRENT HILLS FAMILY HEALTH TEAM - PATIENT APPLICATION FORM

NAME: First: ________________________ Middle: ________________ Last: _______________________

Date of Birth: Month___________________ Day______________ Year_________________

Address of PRIMARY RESIDENCE:
(number, street) ____

(town, postal code) ____

Phone number (area code + number): ____

Health Card Number: _____________________________________ **Expiry Date:** _________________

Email Address: (very important) ____

Last Primary Care Provider (doctor or nurse practitioner):
Dr/NP name: ____________________________ Town where they practice:__________________________

Are you still a patient in this practice (circle one): Yes / No
If "no", when were you last in this provider's practice (month/year)? ___________________

I would like to register with (check one only):

- ☐ a nurse practitioner
- ☐ a doctor
- ☐ either a nurse practitioner or a doctor

Your Medical Conditions Current (e.g. high blood pressure) & past (e.g. breast cancer 2015):

_________________________________ _______________________________

_________________________________ _______________________________

_________________________________ _______________________________

Your Current Medications (e.g. ramipril 5 mg for blood pressure):

_________________________________ _______________________________

_________________________________ _______________________________

_________________________________ _______________________________

_________________________________ _______________________________

Send completed form to
email: kreid@thfht.com *OR*
mail: THFHT, 119 Isabella St., 2nd Floor, Campbellford, ON, K0L 1L0

Office use only: *Date received* _______________ *Reviewed by:* _______ *ACTP*:__________