

## Ministry of Health and Long-Term Care

## Patient Enrolment and Consent to Release Personal Health Information

M	icrofi	lm i	ISA	only	,

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 addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 — I want to enrol myself with the fam	nily doctor ic	lentified in	Section 4		TO THE PERSON OF	
Last Name	First Nan		occion 4	Second Nam	e	
8						
Health Number Version	na=111	Apartment #	Street No. and	Name or PO Box But	ral Route, General Delivery	
Code	Mailing Address		ou out no. une	Trancon .o. box, nu	rai noute, deficial Delivery	
Date of Birth (yyyy/mm/dd) Sex	-	City/Town				
Jane 6: 2.11.11 (Jyyyy), Illininisasy	ET Fores Van	City/Town			Postal Code	
Send notices from my family doctor's office to me by:	Residence	Apartment #	Street No. and	Name or Lot, Concess	Concession and Township	
regular mail email (if possible)	Address			*		
Email Address:	or same as	City/Town			Postal Code	
	mailing address					
Section 2 - I want to enrol my child(ren) under	16 and/or de	pendent ad	ult(s) with t	he family doctor is	dentified in Section 4	
A Last Name	First Nam	е	sigo, with t	Second Name		
Health Number Version	Mailing	Apartment #	Street No. and	Name or PO Box Bur	al Route, General Delivery	
Code	Address	"	51.551 115. and	Nume of 1.0. Box, Till	ar noute, deficial Delivery	
Date of Birth (yyyy/mm/dd) Sex	solv or huns man	City/Town			- In the s	
	same as	City/ fowii			Postal Code	
	☐ Section 1					
I am this person's parent	Residence Address	Apartment #	Street No. and	Name or Lot, Concess	ession and Township	
legal guardian						
attorney for personal care	or same as	City/Town			Postal Code	
	Section 1					
Last Name	First Name	9		Second Name		
Health Number Version	Mailing	Apartment #	Street No. and	Name or P.O. Box. Rura	al Route, General Delivery	
Code	Address >			, , , , , , , , , , , , , , , , , , , ,		
Date of Birth (yyyy/mm/dd) Sex	or	City/Town			Postal Code	
, , , , , , , , , , , , , , , , , , ,	same as Section 1	,			l Osiai Code	
I am this person's	Residence	Apartment #	Street No. and	Name or Lot, Concessi	ion and Township	
parent	Address	To the			an an in a trivial in p	
legal guardian	Bre Patien C	City/Town			Postal Code	
attorney for personal care	same as	,			Fosial Code	
	Section 1	0 " 1				
Section 3 – Signature		Section 4 –	- Family dod	ctor information		
I have read and agree to the Patient Commitment, the Consen Personal Health Information and the Cancellation Conditions of	on the back of					
this form. I acknowledge that this Enrolment is not intended to binding contract and is not intended to give rise to any new leg	he a legally	PG103	06_	T.		
between my family doctor and me.	gai obligations			***************************************		
I am signing on behalf of (check all that apply)						
myself child(ren) deper		NSON DRIV				
My Name		IROQU	OIS FALLS,	ON POK1E0		
last name first name		BILLING	G NO	GROUP NO		
Signature Date (www/m	our (elel)	DILLIM	C NO.	GROUP NO		
())))////	nm/aa)					
X			(Inclui	de Billing no. and Group	no.)	
Home Telephone No. Work Telephone No.		Family Doctor's		g in and anoup	Date (yyyy/mm/dd)	
		X				