

Ministry of Health and Long-Term Care

Patient Enrolment and Consent to Release Personal Health Information

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.

Microfilm use only

Section 1 – I want to enrol myself with the far	mily doctor i	dentified in	Section 4	K/L,5J3, INFOline tel. 1 888	3 218–9929 or by mail through the
Last Name	me Second Name				
				Gecond Marrie	
Health Number Version		1	1		
Code	Mailing Address	Apartment #	Street No. and I	Name or P.O. Box, Ru	ral Route, General Delivery
Date of Birth (yyyy/mm/dd) Sex	(1.15 president	City/Town		Λ	Postal Code
Send notices from my family doctor's office to me by:	Residence	Apartment #	Street No. and I	Vame or Lot, Concess	sion and Township
regular mail email (if possible) Email Address:	Address	2			
Email Address:	or same as	City/Town			Postal Code
Y	mailing address	, (i)			
Section 2 – I want to enrol my child(ren) under	16 and/or de	ependent ad	ult(s) with the	e family doctor is	dontified in Coating 4
Last Name	First Nam	10	(-)	Second Name	e a continued in Section 4
Health Number Version	Mailing	Anartment #	Charak Ni - I hi		
Code	Address	Apartment #	Street No. and N	ame or P.O. Box, Rura	al Route, General Delivery
Date of Birth (yyyy/mm/dd) Sex	nworping net	City/Town			Death Out
	Section 1				Postal Code
I am this person's parent	Residence	Apartment #	Street No. and N	ame or Lot, Concess	ion and Township
☐ legal guardian	Address				and the state of t
_	or	City/Town			Postal Code
attorney for personal care	Same as Section 1				
Last Name	First Name	9		Second Name	
				-	191
Health Number Version	Mailing Suppl	Apartment #	Street No. and Na	ame or P.O. Box, Rura	I Route, General Delivery
	Address			,	Solly Solly
Date of Birth (yyyy/mm/dd) Sex	or	City/Town			Postal Code
	Section 1				
I am this person's parent	Residence Address	Apartment # 5	Street No. and Na	ame or Lot, Concession	on and Township
legal guardian	ine Panyot C	City/Town			
attorney for personal care	same as	City/Town			Postal Code
Section 3 – Signature	Section 1	Coation 4	F 1400		
have read and agree to the Patient Commitment, the Consent	A A COLUMN	Section 4 –	ramily docto	or information	(1/8/
his form. Lacknowledge that this Englinent is not intended to	on the back of	70400			
pinding contract and is not intended to give rise to any new legoetween my family doctor and me.	pal obligations	PG1030	06		
am signing on behalf of (check all that apply)	11				6.5
myself		58 A ANSON DRIVE			
My Name		IROQUOIS FALLS, ON POK1E0			
last name first name	ľ				
ignature Data (new/ex		BILLING	NO.	GROUP NO	
Date (yyyy/m	m/dd)				
X			(Include I	Billing no. o- J C	2.0
ome Telephone No. Work Telephone No.	F	amily Doctor's	Signature	Billing no. and Group n	o.) Date (yyyy/mm/dd)
) ()		X			in-contract was a second of the second of th
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