

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.C. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218–9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Microfilm use only

Section 1 – I want to enrol myself with the family doctor identified in Section 4				
Last Name	First Name	Second Name		AND THE RESIDENCE OF THE PARTY
Health Number Version	Mailing	Apartment # Street No. and	d Name or P.O. Box, Rural R	oute, General Delivery
Code	Address >			
Date of Birth (yyyy/mm/dd) Sex		City/Town		Postal Code
, , , , , , , , , , , , , , , , , , ,				
Cond nations from my family destar's office to me by:	Residence	Apartment # Street No. and	d Name or Lot. Concession	and Township
Send notices from my family doctor's office to me by:	Address >			
regular mail email (if possible)  Email Address:	or	City/Town		Postal Code
Littali Address.	same as mailing			
	address			27 1 · · · · · · · · · · · · · · · · · ·
Section 2 – I want to enrol my child(ren) under			Second Name	numed in Section 4
Last Name	First Name		Second Name	
Health Number Version	Mailing	Apartment # Street No. and	d Name or P.O. Box, Rural F	Route, General Delivery
Code	Address			,
Date of Birth (yyyy/mm/dd) Sex	or	City/Town		Postal Code
Date of Birth (yyyymmiod)	same as	City/10Wii		Toolar oodo
	Section 1	Apartment # Street No. an	d Name or Lot Concession	and Township
I am this person's parent	Residence Address	Apartment # Street No. an	d Name of Lot, Concession	and rownship
legal guardian	or	City/Town		Postal Code
attorney for personal care	same as	Skyr rown		
, ,	Section 1		Second Name	
Last Name	First Name	;	Second Name	
		To		
Health Number Version Code	Mailing Address	Apartment # Street No. and	d Name or P.O. Box, Rural F	Route, General Delivery
Date of Birth (yyyyimmidd) Sex	or same as	City/Town		Postal Code
	Section 1			
I am this person's parent	Residence Address	Apartment # Street No. an	nd Name or Lot, Concession	and Township
legal guardian	or	City/Town		Postal Code
attorney for personal care	same as			
	Section 1	Section 4 – Family de	actor information	
Section 3 – Signature	at to Polosco	Section 4 – Family u	octor imormation	
I have read and agree to the Patient Commitment, the Conse Personal Health Information and the Cancellation Conditions				
this form. I acknowledge that this Enrolment is not intended t binding contract and is not intended to give rise to any new le				
between my family doctor and me.				
I am signing on behalf of (check ail that apply)				
	endent adult(s)			
My Name lost name first name.			····	
Signature Date (yyyy/mm/dd)				
X		(In	clude Billing no. and Group n	0.)
Home Telephone No. Work Telephone No.	<del></del>	Family Doctor's Signature	, , , , , , , , , , , , , , , , , , ,	Date (yyyy/mm/dd)
( )		x		
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