West Nipissing Ouest
Gaawbiiwnong Nbisiing

Family Health Team
Équipe de santé familiale
Mno-Maadziwin Enching Enankiiwaad

Patient/Client Application Form

Privacy Statement: By submitting this form, you understand that your information is collected and held by the WNFHT and shared with affiliated family physicians and their staff in accordance with the *Ontario Personal Health Information Protection Act*. If you have any questions about WNFHT privacy and security practices, or if you wish to withdraw your consent for the collection and use of your personal information, please contact us in writing with letter addressed to: 77-B Front St., Sturgeon Falls ON P2B 2H2 (attention: Privacy Officer)

Please answer each question as complete as possible (except where answers are optional).
INCOMPLETE APPLICATIONS MAY BE REJECTED.

First Name:	Last Name:	
Date of Birth (*Day/Month/Year*):		
Preferred Language:	☐ French	☐ English
Do you have a family physician or nurse practitioner?	☐ Yes	☐ No
If yes, your current family physician or nurse practitioner:		
If yes, the date of your last appointment:		
Current specialist(s):		
Are you pregnant?	☐ Yes	☐ No
CONTACT INFORMATION:		
Street Address:	Town:	
Email:	Postal Code:	
Home Phone:	May we leave a message at this number? ☐ Yes ☐ No	
Cell Phone:	May we leave a message at this number? ☐ Yes ☐ No	
Other Phone:	May we leave a message at this number? ☐ Yes ☐ No	
OPTIONAL:		
Gender:		
Name of Spouse, if applicable:		
Parents' Names: (if applicant is under 16)		
Would you prefer to have a man or woman family physician? (circle which) Man / Woman / No preference	Please note that your answer will not guarantee that you get your preference.	

Turn page over to continue....

West Nipissing Ouest
Gaawbiiwnong Nbisiing

Family Health Team
Équipe de santé familiale
Mno-Maadziwin Enching Enankiiwaad

Patient/Client Application Form

OTHER APPLICANTS:
Complete this section only if you are seeking a family physician for other family members as well as yourself.
List names of family members applying in addition to you, their ages and their relationship to you:

Name	Age	Relationship to You (e.g. spouse, child)
1.		
2.		
3.		
4.		
5.		

Note: A New Patient/Client Application Form must be completed for each applicant listed above.

MEDICAL CONDITIONS:
Please check any that apply to you.

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic bronchitis / respiratory problems
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Heart problems (angina pectoris, myocardial infarction)
- ☐ Hypertension
- ☐ Mental illness
- ☐ Musculo-skeletal problems (e.g. back, knee, or hip pain)
- ☐ Substance abuse

☐ Other (please specify): ______________________________

MEDICATIONS:
List all medications and/or vitamins you currently or regularly take, or attach a list of your medications, including narcotics.

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Additional comments or extra information:

____

____

____

Signature: ______________________________ Date: ____________________

Please return by email, mail, or drop-off to: **Address: 77-B Front Street, Sturgeon Falls, ON P2B 2H2**

The above email is not monitored regularly and is intended for application submission only. For emergencies please go to the nearest emergency room or dial 911.

Please note that our call volumes have been very high during the pandemic. Please do not call to inquire on the status of your application, the Physician offices will contact you once there is availability. In the meantime we encourage you to contact Health Care Connect at: 1-800-445-1822 for information on other Physicians in the area.