Central Lambton Family Health Team
4130 Glenview Road, Unit 3
PETROLIA, Ontario N0N 1R0
Telephone 519-882-2500 Fax 519-882-4321

Contact and Medical Information Sheet

Surname ____________________ Given Name (s) ____________________

Date of Birth ____________________ Age ________ Gender (circle) Male Female

Address: Number and Street ______________________________ Apt Number ________

City ____________________ Postal Code ____________ Home Phone No. ____________

Alternate Contact No. (eg cell) ____________ Type (ie. Work, cell) ____________ Health Card Number + Version code ____________ Expiry date ________

MEDICAL INFORMATION

Y	N	Diabetes: Type 1 Type 2	Y	N	Irritable Bowel Syndrome
Y	N	High Blood Pressure	Y	N	Heartburn, Indigestion, GERD
Y	N	High Cholesterol	Y	N	Crohn's Disease, Colitis
Y	N	Chest Pain, Angina	Y	N	Chronic Headaches
Y	N	Heart Failure	Y	N	Thyroid Disease: Hypothyroidism hyperthyroidism
Y	N	Heart Attack, when	Y	N	Lupus
Y	N	Emphysema	Y	N	Kidney Disease
Y	N	Asthma	Y	N	Hernia
Y	N	Problems with ears, eyes, nose	Y	N	Urinary/Bowel Incontinence ostomy colostomy
Y	N	Arthritis, joint pain: knees hips ankles wrist hands back Other:	Y	N	Have you ever had: Blood Clot, Deep Vein Thrombosis, Pulmonary Embolism
Y	N	Chronic Back Pain	Y	N	Fibromyalgia
Y	N	Anemia	Y	N	Skin Condition
Y	N	Sleep Apnea	Y	N	COPD
Y	N	Cancer	Y	N	Stroke
Y	N	Mental health issues: Anxiety Depression Panic attacks Bipolar Psychosis Schizophrenia PTS Other	Y	N	Other:
Y	N	Smoker Years smoking ______ Ex-smoker Year quit ______ If currently smoker, I would like to quit smoking (circle) yes no	Y	N	Drug Allergies : list and type of reaction (rash, nausea, anaphylaxis)

MEDICATIONS

Name	Dose	Frequency

PAST SURGERIES	DATE

FAMILY HISTORY OF SIGNIFICANT MEDICAL ISSUES — RELATION
EXAMPLE *diabetes* — *father*

Patient Declaration

Due to the current family doctor shortage, Patients without a current family doctor within Sarnia Lambton will be given a priority. Please check the box that most closely applies to you:

- ☐ My previous family physician has retired or moved
- ☐ My previous family physician is still practicing but no longer provides my care.
- ☐ Until now, I have not had or felt the need to have a family physician
- ☐ I have relocated to Sarnia-Lambton and do not have a family physician in the Community
- ☐ Other__________________________________

Name of previous/current family physician: __________________________________

Date last seen: ______________________ Location:______________________

PLEASE NOTE:

- Completion of this form does not guarantee entrance into our practice.
- **Central Lambton Family Health Team will maintain a strict narcotic prescription policy in order to minimize the potential for abuse. Narcotics will only be prescribed for legitimate pain control purposes. Extended/prolonged narcotic prescription abuse will be warned and subject to termination of the patient-physician relationship.**

Please be sure this form is fully completed. Please fill out a separate form for each family member and return all forms together.
By signing below, I acknowledge I have read and understood all policies and procedures, as well as answered all questions truthfully. If responses on this form are intentionally incorrect, the patient-physician relationship may be terminated.

__________________________ ______________________
Signature Date

CENTRAL LAMBTON FAMILY HEALTH TEAM

Dr. J. Butler Dr. E. Daniel Dr. F. Al-Dhaher
Dr. J. Mall Dr. N. Taylor Dr. S. Cooper
Dr. A. Leonard

4130 GLENVIEW AVE. UNIT 3,
PETROLIA, ONTARIO N0N 1R0
Telephone 519-882-2500 Fax 519-882-4321

REQUEST FOR MEDICAL RECORDS

Dear Dr: ________________________________

The following patient has come under the care of Dr.________________

( ) and would like a copy of his/her medical records transferred.

( ) does **not** wish to have his/her medical records transferred, wishes to notify you of change ONLY.

PATIENT: ________________________________

DATE OF BIRTH ________________________________

OHIP NUMBER ________________________________

CURRENT ADDRESS: ________________________________

____

____

TELEPHONE ________________________________

I agree to release my medical records to Dr. ________________________________.
I understand that there may be a charge for the transfer of records and I am aware that I will be responsible for any fees associated with transfer.

________________________________ ________________________________
Patient Signature (Print Name beside signature) Witness (Print name beside Signature)

________________________________ ________________________________
Date Date

CENTRAL LAMBTON FAMILY HEALTH TEAM

Dr. J. Butler, Dr. E. Daniel, Dr. F. Al-Dhaher,

Dr. J. Mall, Dr. N. Taylor, Dr. S. Cooper, Dr. A. Leonard

4130 Glenview Ave., Unit 3

Petrolia, Ontario N0N 1R0 519-882-2500

Welcome to Central Lambton Family Health Team.

In order to serve you better, we ask that you complete the following:

Name:____

Complete Mailing address: - Please include 911 number or P O Box

____

____

____

Cell phone # (if applicable) ______________________________

Employer Name ______________________________________ Phone #____________________

EMERGENCY CONTACT:

Name: ____ Phone #______________________

Relationship: ____

ALTERNATE CONTACT:

Name: ____ Phone #______________________

Relationship: ____

PHARMACY USED FOR PRESCRIPTIONS

Pharmacy Name _________________________________ Location _______________________________

Previous Doctor _________________________________ Location _______________________________

We ask that you inform our office of any changes to the above information.

Ontario Ministry of Health

Microfilm use only

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 (i), 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.

Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by: ☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

or ☐ same as mailing address

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

or ☐ same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

or ☐ same as Section 1

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of *(check all that apply)*

☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 – Family doctor information

BILLING NO. 032256 GROUP NO. BCBQ

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

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