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	Dr. A. Hijazi	Dr. P. Moon

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.

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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 and 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
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 X Another Gender

____________________ 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

__________ 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

PAST SURGERIES	DATE

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

FAMILY HISTORY OF SIGNIFICANT MEDICAL ISSUES	RELATION

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

Patient Enrolment and Consent to Release Personal Health Information

You are being asked to enrol with a primary health care **Group**. A primary health care group is a group of family doctors and other health care providers who are working together to give you and your family continued access to quality primary care services.

Enrolling with a primary health care group is your choice. If you choose to enrol, please fill out this form **using a black or blue ball point pen** as follows:

- To enrol **yourself** . . . . *complete* ***Sections 1 & 3***
- To enrol **yourself** and up to **two** children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care . . . . *complete* ***Sections 1, 2 & 3***
- To enrol children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care but **not** yourself . . . . *complete* ***Sections 2 & 3***
- To enrol **more than two** children under 16 years of age or dependent adults for whom you are a parent, legal guardian or attorney for personal care . . . . *complete* ***Sections 2 & 3*** *on a separate form*

Note: If the mailing address includes a post office box (P.O. Box), rural route (R.R.), or general delivery, you must also complete the residence address.

If your primary health care group is not already identified or is incorrectly identified in Section 4, please print the name of the Group inside the box in Section 4.

Your Group will acknowledge your enrolment form in Section 4 and will provide you with a copy for your records.

For questions about enrolment and consent, filling out this form or to receive additional forms, please call INFOline at 1 888 218–9929 (TTY 1 800 387–5559).

Instructions:

1. Remove this instruction page.
2. Complete the form as instructed above.
3. Read the back of the form and Section 3 before signing and dating it.
4. Return all copies of the completed form to your Group or in the envelope provided.

PG11943

(Un formulaire bilingue est également disponible. Pour en recevoir un exemplaire, composez le 1 888 218-9929)

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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 (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.

Section 1 - I want to enrol myself with the Primary Health Care Group identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

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

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 Group identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

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

or ☐ same as Section 1

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

I am this person's

☐ parent

☐ legal guardian

☐ attorney for personal care

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

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

or ☐ same as Section 1

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

I am this person's

☐ parent

☐ legal guardian

☐ attorney for personal care

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, Group 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 - Primary Health Care Group Information

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G

(Include Billing no. and Group no.)

Signature on behalf of Group X | Date *(yyyy/mm/dd)*

Office use Only *(print)* | Billing Number

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