Ontario

Ministry of Health and Long-Term Care

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

One form per adult patient. Photocopy for additional adult family members.

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

Last Name	First Name	Second Name
Shri	Nithya	

Health Number: 6547657622 Version Code: AB

Date of Birth *(yyyy/mm/dd)*: 19981202 Sex: ☐ M ◉ F

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

Email Address: nithu@gmail.com

Mailing Address ▶ Apartment #: 123 | Street No. and Name or P.O. Box, Rural Route, General Delivery: ABC street | City/Town: Milton | Postal Code: L2K3A5

Residence Address ▶ ☑ or same as mailing address

Apartment #: 123 | Street No. and Name or Lot, Concession and Township: ABC street | City/Town: Milton | Postal Code: L2K3A5

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
Neha	Shri	

Health Number: 6547657622 Version Code: AC

Date of Birth *(yyyy/mm/dd)*: 20200819 Sex: ☐ M ◉ F

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

Mailing Address ▶ ☑ or same as Section 1

Apartment #: 123 | Street No. and Name or P.O. Box, Rural Route, General Delivery: ABC street | City/Town: Milton | Postal Code: L2K3A5

Residence Address ▶ ☑ or same as Section 1

Apartment #: 123 | Street No. and Name or Lot, Concession and Township: ABC street | City/Town: Milton | Postal Code: L2K3A5

B

Last Name	First Name	Second Name
Krithi	Sai	

Health Number: 6547757622 Version Code: AB

Date of Birth *(yyyy/mm/dd)*: 20220514 Sex: ☐ M ◉ F

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

Mailing Address ▶ ☑ or same as Section 1

Apartment #: 123 | Street No. and Name or P.O. Box, Rural Route, General Delivery: ABC street | City/Town: Milton | Postal Code: L2K3A5

Residence Address ▶ ☑ or same as Section 1

Apartment #: 123 | Street No. and Name or Lot, Concession and Township: ABC street | City/Town: Milton | Postal Code: L2K3A5

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 Nithya Shri first name

Signature: X

Date *(yyyy/mm/dd)*: 2024/05/12

Section 4 Family doctor information

Dr.Farrell

Home Telephone No.: (12345678901

Work Telephone No.: (23456789012

Family Doctor's Signature: X

Date *(yyyy/mm/dd)*:

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