

NEW PATIENT APPLICATION

Date: _____

Name (as it appears on your medical card): _____

Date of Birth (mm/dd/yyyy): _____ Gender: _____

PHIN (9 digit): _____ MHSC (6 digit): _____

Current Address: _____

City: _____ Prov: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Current/Previous Family Physician (if applicable): _____

Medical Conditions:

Current Medications:

Referred by (if applicable): _____

Preference (circle one): Male doctor/Female doctor/No preference

Please ensure your writing is legible or we may not be able to process your request

Application Disclaimer

Thank you for your interest in our clinic. Applications are processed in the order they are received. Completion of this form does not guarantee acceptance. You will be notified of a Meet and Greet appointment when an opening arises.