New Patient Application:

Date: _____

Toronto Western
Family Health Team
Garrison Creek
Bathurst

Information about you

Last name (Surname): _____

First name (Given name): _____

Birth date: Day: _____ Month: _____ Year: _____

Gender: ☐ Male ☐ Female

Information about your gender identity (optional): _____

Street address: _____ Suite or Apartment #: _____

City: _____ Province: _____ Postal code: _____

Health card number (OHIP #): _____

Version code: _____ Health card expiry date: _____

How to contact you

Home phone number: _____ Business phone number: _____

Mobile phone number: _____ Email: _____

We will contact you for your first appointment through email, if you prefer another method, please check one:

☐ Home phone ☐ Business ☐ Mobile

What is the preferred time of day for first appointment? Please check one:

☐ Any time of day (morning or afternoon)

☐ Morning only

☐ Afternoon only

How did you hear about us? Please check one:

☐ Family or friends ☐ Walk by ☐ Community (school, library, community agency)

☐ Ad (newspaper) ☐ Internet search or social media ☐ Other: _____

Anyone in your family a registered patient? ☐ Yes ☐ No

If **yes**, would you like to join the same physician? ☐ Yes ☐ No

If yes, name of the family member: _____

If yes, name of the physician: _____

If **no** to the above question(s), please complete this section:

Do you have a preference for a physician? ☐ None ☐ Male ☐ Female

Preferred physician name: _____

Your family

Anyone else in your household seeking a family physician? ☐ Yes ☐ No

If Yes:

Last name: _____ First name: _____

Birth date: Day: _____ Month: _____ Year: _____

Gender: ☐ Male ☐ Female

Information about your gender identity (optional): _____

Relationship: _____

Health card number (OHIP #): _____

Version code: _____ Health card expiry date: _____

Phone number (if different from person completing form): _____

#2

Last name: _____ First name: _____

Birth date: Day: _____ Month: _____ Year: _____

Gender: ☐ Male ☐ Female

Information about your gender identity (optional): _____

Relationship: _____

Health card number (OHIP #): _____

Version code: _____ Health card expiry date: _____

Phone number (if different from person completing form): _____

#3

Last name: _____ First name: _____

Birth date: Day: _____ Month: _____ Year: _____

Gender: ☐ Male ☐ Female

Information about your gender identity (optional): _____

Relationship: _____

Health card number (OHIP #): _____

Version code: _____ Health card expiry date: _____

Phone number (if different from person completing form): _____

#4

Last name: _____ First name: _____

Birth date: Day: _____ Month: _____ Year: _____

Gender: ☐ Male ☐ Female

Information about your gender identity (optional): _____

Relationship: _____

Health card number (OHIP #): _____

Version code: _____ Health card expiry date: _____

Phone number (if different from person completing form): _____

Prior to your first appointment, there are a number of forms which will need to be completed, please arrive 15 minutes prior to your appointment to complete the forms at the clinic.

Do you need an interpreter? ☐ Yes ☐ No Language: _____

Comments:

_____

_____

_____

_____

We currently have a high volume of requests to join our clinic.
We will do our best to respond to your request within a week.

Patient Consent for E-mail Communications

Toronto Western Family Health Team
Garrison Creek
Bathurst

Your care provider can communicate with you and the others (named below) using e-mail but you need to understand the risk of using e-mail.

- The security of e-mail is not guaranteed. Messages sent to, or from, your provider may be seen by the others using the internet. E-mail is easy to forget, may be accidentally forwarded, and may exist indefinitely. For this reason, it is recommended you do not use e-mail to discuss information you think is sensitive. If you decide to use e-mail, please tell you care provided if there are certain types of information you do not want to discuss by e-mail.
- Do not use e-mail in an emergency because e-mail can be delayed or your care provider may not be able to read it soon enough.

Please note:

- Your provider will talk to you about which type of conversations you are both comfortable having over email (e.g. scheduling appointments). Your care provider may not feel comfortable discussing some topics by e-mail (e.g. to give test results) and will tell you if another way will be used.
- Your care provider may make decisions about your care based on information you provide in e-mail.
- If an email has information that is important to your clinical care it will be copied or summarized into your medical record-much like a phone conversation.
- E-mail may be forwarded or read by other UHN staff who need the information to provide you with care. Your care provider will tell you if another person will read or reply to your e-mail on their behalf.

This consent form lets us know when we may use e-mail to communicate with you or others who are outside the hospital.

If at any time you decide that you no longer want to communicate by e-mail please tell your care provider as soon as possible. Your care provider will do the same.

By signing below, you accept the risk of using e-mail and agree to the following:

To be able to communicate with you via email, we need to have your consent.

Communicate with me by e-mail at (e-mail address): ☐ Yes ☐ No

If Yes, e-mail address: _____