West Elgin Community Health Centre

West Elgin Community Health Centre
Application for Medical Services

Name: _____ / _____ / _____
First **Middle** **Last Name As it appears on Health Card**

Street: _____ _____ _____ _____
Box # **Apt. # or R.R #** **House # or 911 #** **Street Name**

_____ _____ _____
City / Town **Province** **Postal Code**

Health Card OHIP #: _____ **Version # :** ____ **Expiry:** _____ / _____/_____
DD **MM** **YYYY**

Date of Birth: _____ /_____ /_____
Day Month Year

Please list telephone numbers where you can be reached:

Home: _____ **Cell:** _____ **Work:** _____

What number do you want us to use first? □ **Home** □ **Cell** □ **Work**

At what number(s) can we leave a voice message – check all that apply. □ **Home** □ **Cell** □ **Work**

Current Care Providers:

Do you currently have a Family Doctor or Nurse Practitioner (provider)? □ **Yes** □ **No**

Care Providers Name: _____ **City:** _____

Approximately how many appointments do you typically require from doctor/nurse practitioner each year? This helps us to divide clients with more frequent needs among providers: _____**/ year**

If you do not currently have a provider, who was your last primary care provider?

Care Providers Name: _____ **Date last see:** ____/_____/_____
Day Month Year

_____ **Date:** _____/_____/_____
Signature **Day** **Month** **Year**

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For Centre Use only

1 2 3 4 Provider _____ Time _____