Kawartha North
Family Health Team
50 Colborne St., PO Box 129
Fenelon Falls, ON K0M 1N0
Tel: 705.887.3535 **Fax**: 705.887.3530

Patient Registration Form

(Complete one form for each family member)

Name ______________________________ Female ☐ Male ☐

Address ______________________________ Postal Code ____________

Telephone (   ) ____________________ Email ______________________________

Date of Birth ____________________ Age ______ Parent/Guardian (if under 18) ______________________________

Health Card # ____________________ Version Code __________ Expiry Date ____________________

Emergency Contact (Name, Relationship, Telephone) ______________________________

Employer: ______________________________

Do you have a family doctor or nurse practitioner? Yes ☐ No ☐ Where ____________________

Name of last doctor/practitioner ____________________ Have you/would you discharge them? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐ Expected Due Date ____________________

Drug/environmental allergies ______________________________

Current Medications (list both prescription and over-the-counter)

Medication	Dosage	How often?	Medication	Dosage	How often?

Current Illnesses and past Surgeries

Illness or Surgery	Year of Diagnosis or Surgery?	Illness or Surgery	Year of Diagnosis or Surgery?

(Use the back of this page to give additional information that is important to your health care)

Signature ______________________________ **Date** ______________________________