Waiting List Patient Information

Last Name ______________________________ First Name _______________________________ Initial ______________

Date of Birth ____________________________ Gender: Female Male Other _______________

Address ____

City ___________________________________ Postal Code ____

Home Phone: ___________________________ Work # __________________________ Cell # ______________________

E-mail ____

Have you been a patient of East Wellington Family Health Team in the past? Y N (please circle)

Do you currently have a physician? If yes, Name _______________________________________ City _______________

Family Member Enrolment

Please list family members 15 years of age or under that you would like to have enrolled

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Last Name ______________________________ First Name _______________________________ Initial __________

Date of Birth ____________________________ Gender: Female Male Other _______________

Relationship to you: ____

Last Name ______________________________ First Name _______________________________ Initial __________

Date of Birth ____________________________ Gender: Female Male Other _______________

Relationship to you: ____

Last Name ______________________________ First Name _______________________________ Initial __________

Date of Birth ____________________________ Gender: Female Male Other _______________

Relationship to you: ____

Last Name ______________________________ First Name _______________________________ Initial __________

Date of Birth ____________________________ Gender: Female Male Other _______________

Relationship to you: ____

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*Please note that **information is not secure when sent over the form of email*** If you choose to e-mail this form, you are consenting to the use of an unsecure site and EWFHT will assume you allow this liability.