East Wellington Family Health Team

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.