North Hastings Family Health Team

REGISTRATION FORM

(Please Print)

Today's Date:	Office use only :

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar/CL ☐ Div ☐ Sep ☐ Wid ☐
Health card	VC	EXP	Home phone :	Birth date:	Age: / Sex: ☐ M ☐ F
Street address:	P.O. box:	City:	Municipality:		
Postal Code:	Occupation:	Employer:			
Next of Kin Name:	Phone:				
Pharmacy of choice:	Insurance plan: Private ☐ ODB ☐ None ☐				
Do you currently have a family doctor or nurse practitioner ☐No ☐ Yes, if so where?					

MEDICAL HISTORY

Drug or environmental allergies :____

Are you pregnant ☐No ☐ Yes if so what is your due date?

Do you currently have or were you ever diagnosed with:

☐ Diabetes	☐ Cancer, Specify type: ____________________
☐ High blood pressure	☐ Asthma or COPD
☐ Arthritis	☐ Other:
☐ Heart disease	☐ Other:

Past surgeries:

MEDICATIONS

(Please list ALL vitamins/minerals, herbal, prescribed, and over the counter medications-even if just taken occasionally)

Patient/Guardian signature	*Date*

By signing this form I acknowledge that this information will be shared with the Bancroft Primary Care Waiting List (including Bancroft FHT)