All data collected is for the purpose of providing you with the best possible care. If you would prefer to discuss any part of this form in person, please leave that section blank.

WINDSOR
Family | Health | Team

PATIENT ENROLMENT DATA

Before completing this enrolment questionnaire please read our Your Right to Privacy statement that outlines our commitment to privacy, legislative responsibility, collection, uses and disclosures, your choices, safeguards and how to respond to privacy concerns.

Last Name: _____ First Name: _____ Initial: _____

Name you prefer to go by: _____

Date of birth: _____

Health Card Number: _____ Version Code: ____ Expiration:_____

Street Address:

_____

_____

City: _____ Postal Code: _____

Primary Phone: _____ ☐ Home ☐ Mobile/Cell ☐ Work ☐ Other

Secondary Phone: _____ ☐ Home ☐ Mobile/Cell ☐ Work ☐ Other

Emergency Contact (name): _____ Relationship_____

Emergency Contact Phone Number: _____

Patients under 16 years of age are not required to fill the remainder of the form

What pronouns do you prefer that we use when talking about you? (Check all that apply):

☐ She/her/hers
☐ He/him/his
☐ They/them/theirs
☐ Other: _____

What is your sex or current gender? (Check all that apply)

☐ Male ☐ Female ☐ TransMale/Transman
☐ TransFemale/Transwoman ☐ Genderqueer ☐ Two-spirit
☐ Additional Category (Please specify): _____
☐ Decline to State

What sex were you assigned at birth?

☐ Male ☐ Female ☐ Decline to State

This information will not be shared with any person outside of your circle of care without your consent, unless legally required, nor will it be used to determine patient eligibility as WFHT makes every effort to provide care to anyone and everyone.

All data collected is for the purpose of providing you with the best possible care. If you would prefer to discuss any part of this form in person, please leave that section blank.

Which race category best describes you?

☐ Black
☐ East/Southeast Asian
☐ South Asian
☐ Do not know
☐ Decline to State
☐ Latino
☐ Middle Eastern
☐ White
☐ Indigenous (First Nations, Metis, Inuit)
☐ Another race category: _____

What is your country of origin? ☐ Canada ☐ Other _____
☐ Date of arrival in Canada: _____
Primary Language: _____ ☐ Written ☐ Spoken
Secondary Language: _____ ☐ Written ☐ Spoken

What is your occupation: _____

What was your approximate total family income before taxes last year?

☐ $0 – $29,999
☐ $30,000 – $59,999
☐ $60,000 – $89,999
☐ $90,000 – $119,999
☐ $120,000 – $149,999
☐ $150,000 or more
☐ Prefer not to answer
☐ Do not know

How many people does this income support? _____

Former Family Physician:

_____

Preferred Pharmacy Name:

_____

Preferred Pharmacy Address:

_____

_____

Do you wish to enrol for communications from WFHT via email? This will be included an invitation to register for our patient portal where you can book your appointments online.

☐ Yes ☐ No

If Yes, what is your e-mail address: _____

Please take the time to read over the terms and conditions that will be sent to your email address or visit www.windsorfht.ca/patient-info

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Personal & Family Medical History

This section asks questions about specific medical problems you have now or have had at any time in the past. It also asks about family members with specific conditions. Please check all that apply to you.

Please list your medications:

Please list any previous surgeries including the year they occurred:

Please list any allergies and the associated reaction:

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Have you ever

Been diagnosed with diabetes?	**☐Yes**	**☐No**
Felt like you are thirsty all of the time?	**☐Yes**	**☐No**
Felt like you need to urinate all of the time?	**☐Yes**	**☐No**
Known of a family history of diabetes?	**☐Yes**	**☐No**
Been diagnosed with gestational diabetes (diabetes during pregnancy)	**☐Yes**	**☐No**
Been diagnosed with high blood pressure?	**☐Yes**	**☐No**
Been diagnosed with high cholesterol?	**☐Yes**	**☐No**
Known of a family history of high cholesterol?	**☐Yes**	**☐No**
Had a heart attack?	**☐Yes**	**☐No**
Had heart surgery?	**☐Yes**	**☐No**
Had heart stents placed?	**☐Yes**	**☐No**
Experienced chest pain?	**☐Yes**	**☐No**
Known of a family history of heart attacks?	**☐Yes**	**☐No**
If yes, at what age did the family member have one? _____		
Had a stroke?	**☐Yes**	**☐No**
Had a mini-stroke (Transient ischemic attack - TIA)?	**☐Yes**	**☐No**
Been diagnosed with other heart disease?	**☐Yes**	**☐No**
Been diagnosed with peripheral arterial disease?	**☐Yes**	**☐No**
Been diagnosed with abdominal aortic aneurysm?	**☐Yes**	**☐No**

If you answered yes to any of these questions, please provide brief details:

_____

_____

_____

Have you ever

Been diagnosed with colon, bowel, or rectal cancer?	**☐Yes**	**☐No**	
Had colon cancer screening in the past?	**☐Yes**	**☐No**	
If yes, what kind?	**☐FOBT/FIT**	**☐Colonoscopy**	
Had an abnormal FOBT/FIT/Colonoscopy?	**☐Yes**	**☐No**	
Had colon or rectal surgery?	**☐Yes**	**☐No**	
Had rectal bleeding?	**☐Yes**	**☐No**	
Had blood in your stool?	**☐Yes**	**☐No**	
Had persistent constipation?	**☐Yes**	**☐No**	
Know of a family history of colon or rectal cancer?	**☐Yes**	**☐No**	
Been diagnosed with other bowel disease?	**☐Yes**	**☐No**	

If you answered yes to any of these questions, please provide brief details:

_____

_____

_____

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Have you ever

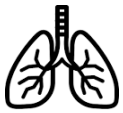
Been diagnosed with depression?	**☐Yes**	**☐No**
Been diagnosed with generalized anxiety?	**☐Yes**	**☐No**
Been diagnosed with bipolar disorder?	**☐Yes**	**☐No**
Known of a family history of bipolar disorder?	**☐Yes**	**☐No**
Been diagnosed with schizophrenia?	**☐Yes**	**☐No**
Known of a family history of schizophrenia?	**☐Yes**	**☐No**
Received treatment from a psychiatrist or psychologist?	**☐Yes**	**☐No**
Received treatment from a therapist?	**☐Yes**	**☐No**

If you answered yes to any of these questions, please provide brief details:

_____
_____
_____

Have you ever

Smoked cigarettes?		**☐Yes**	**☐No**
If yes, how many per day?	**☐<1/2 pack**	**☐1 pack**	**☐>1pack**
If yes, when did you start smoking?	_____		
If you used to, when did you quit?	_____		
Used other tobacco or nicotine products?		**☐Yes**	**☐No**
Persistently coughed up blood?		**☐Yes**	**☐No**
Had persistent night chills or sweats?		**☐Yes**	**☐No**
Been diagnosed with lung cancer?		**☐Yes**	**☐No**
Known of a family history of lung cancer?		**☐Yes**	**☐No**
Been screened for lung cancer in the past?		**☐Yes**	**☐No**
If yes, how and when?	_____		
Had lung or chest surgery?		**☐Yes**	**☐No**



If you answered yes to any of these questions, please provide brief details:

_____
_____
_____

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This section is intended for biologically female patients. Please skip to the next section if this does not apply to you.

Have you ever

Been diagnosed with breast cancer?	**☐Yes**	**☐No**
Had a mammogram in the past?	**☐Yes**	**☐No**
If yes, when was your last one?	_____	
Had an abnormal mammogram?	**☐Yes**	**☐No**
Had breast surgery?	**☐Yes**	**☐No**
Had nipple discharge or bleeding?	**☐Yes**	**☐No**
Known of a family history of breast cancer?	**☐Yes**	**☐No**
If so, at what age were they diagnosed?	_____	
Known of a family history of ovarian cancer?	**☐Yes**	**☐No**
If so, at what age were they diagnosed?	_____	
Been told you or family member is BRCA positive	**☐Yes**	**☐No**
Had chest wall radiation?	**☐Yes**	**☐No**

If you answered yes to any of these questions, please provide brief details:

_____

_____

Have you ever

Had a pap smear	**☐Yes**	**☐No**
If yes, when was your last one?	_____	
Had an abnormal pap smear?	**☐Yes**	**☐No**
Had uterine or vaginal surgery?	**☐Yes**	**☐No**
Had vaginal discharge	**☐Yes**	**☐No**
Had abnormal vaginal bleeding?	**☐Yes**	**☐No**
Had vaginal bleeding or spotting after sex?	**☐Yes**	**☐No**

If you answered yes to any of these questions, please provide brief details:

_____

_____

This section is intended for biologically male patients. Please skip to the next section if this does not apply to you.

Have you ever

Had difficulty urinating?	**☐Yes**	**☐No**
Had blood or pus in your urine?	**☐Yes**	**☐No**
Been diagnosed with prostate cancer?	**☐Yes**	**☐No**
Know of a family history of prostate cancer?	**☐Yes**	**☐No**
Been screened for prostate cancer in the past?	**☐Yes**	**☐No**
Have you had an abnormal PSA result in the past?	**☐Yes**	**☐No**
If yes, when?	_____	

If you answered yes to any of these questions, please provide brief details:

_____

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This section asks sensitive information about your personal life. This information is obtained to provide you with better healthcare. Your entire circle of care at the Windsor FHT will have access to this information unless you specifically request to limit it to a certain individual(s). You can change this information in the future by discussing with your provider. If you would prefer to discuss any of these questions in person, please feel free to leave this section blank.

☐ If you prefer that this personal information remain protected (only accessible by your primary care provider) please check this box otherwise it will be accessible to other team members (example: dietitian, social worker, nurse etc.) if needed.

Do you identify as:

☐ Asexual ☐ Straight (heterosexual) ☐ Bisexual
☐ Gay ☐ Lesbian ☐ Two-spirit
☐ An identity not listed (please specify): _____
☐ Decline to State

Please describe your sexual activity during the last year:

☐ I did not have any sexual partners
☐ I was in a monogamous relationship with a man (I had sex with one man only)
☐ I was in a monogamous relationship with a woman (I had sex with one woman only)
☐ I had multiple male partners
☐ I had multiple female partners
☐ I had both male and female partners
☐ _____
☐ Decline to State

Please describe your current relationship status (check all that apply):

☐ Single ☐ Married ☐ In a civil union
☐ Divorced ☐ Widowed
☐ In a domestic partnership, living together
☐ Partnered, not living together
☐ In a committed relationship
☐ _____

This section asks sensitive information about exercise, daily habits, and routines. If you would prefer to discuss any of these question in person, please feel free to leave this section blank.

How would you rate your diet?		**☐Poor**	**☐OK**	**☐Healthy**
How often do you exercise?	**☐Never**	**☐Sometimes**	**☐Often**	**☐Daily**
Do you drink alcohol?	**☐Never**	**☐Sometimes**	**☐Often**	**☐Daily**
Do you use any other substances or drugs?			**☐Yes**	**☐No**
If yes, please check any that apply		**☐Marijuana**	**☐Cocaine**	**☐Heroine**
		☐Non-prescription narcotics		
		☐Other(s) _____		

When was the last time you had blood work drawn? _____

This information will not be shared with any person outside of your circle of care without your consent, unless legally required, nor will it be used to determine patient eligibility as WFHT makes every effort to provide care to anyone and everyone.

Ontario **Ministry of Health**

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218–9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 - I want to enrol myself with the Primary Health Care Group identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Mailing Address
Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

Section 2 - I want to enrol my child(ren) under 16 and/or dependent adult(s) with the Group identified in Section 4

A

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ or ☐ same as Section 1
Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Section 1
Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ or ☐ same as Section 1
Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Section 1
Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

Section 3 - Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor, Group and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 - Primary Health Care Group Information

PG00056

(Include Billing no. and Group no.)

Signature on behalf of Group
X

Date *(yyyy/mm/dd)*

Office use Only *(print)*

Billing Number