PATIENT ENROLMENT DATA

Before completing, please read our privacy policy to learn more about our practices regarding collecting, using, disclosing, protecting, and managing personal information. www.windsorfht.ca

Last Name: _____ First Name: _____

Middle Name: _____ Preferred Name: _____

Date of Birth: _____ Sex: _____ Gender Identity: _____

Street Address: _____

City: _____ Postal Code: _____

Health Card Number: _____ Version Code: _____Expiration: _____

Home Phone: _____ ☐ Primary ☐ Secondary

Mobile (Cell) Phone: _____ ☐ Primary ☐ Secondary

Emergency Contact (First and Last Name): _____ Phone: _____

Emergency Contact Relationship: _____

Former Family Physician: _____

Preferred Pharmacy Name/Location: _____

The Windsor Family Health Team is transitioning to a more digital approach for communication, which includes appointment reminders via email.

Please provide your email address: _____

By providing your email address, you agree to receive email communications from WFHT and Ocean by CognisantMD.

By submitting a completed enrolment form, you acknowledge that you have read and agree to our patient rights and responsibilities, as set out in our Welcome Package. A doctor-patient relationship is not established until you have had your first appointment. More information can be found on our website http://www.windsorfht.ca/patient-info.

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Please list any medications you are currently taking

Current Medications (Name/Dose/Frequency)	

Please list previous surgeries and dates

Previous Surgical History and Date Performed	

Please list any allergies and their reactions

Allergy/Reactions	

Are there any other doctors or specialists involved in your care?

Doctor/Specialty	

Information collected is to provide you with the best possible care. If you prefer to discuss a part of this form in person, please leave that section blank. This information will not be shared outside your circle of care without consent, unless legally required, nor will it be used to determine patient eligibility.

Personal and Family Medical History

Please check all that apply. Left checkbox "myself" is if the illness or condition applies to you. The right check box is if there is a family history of an *immediate* family member. (Parent, Grandparents, Siblings, Children).

Condition	Myself	Family	Condition	Myself	Family
Allergies	☐	☐	Gerd	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐
Anxiety	☐	☐	Headaches/Migraines	☐	☐
Arthritis	☐	☐	Heart Attack	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐
Bleeding Disorder	☐	☐	High Cholesterol	☐	☐
Blood Transfusion	☐	☐	Hypertension (high blood pressure)	☐	☐
Bowel Disease	☐	☐	Kidney Disease	☐	☐
Cancer (describe below)	☐	☐	Liver Disease	☐	☐
Congestive Heart Failure	☐	☐	Mental Health Disorder (describe below)	☐	☐
COPD (lung disease)	☐	☐	Nerve/Muscle Disease	☐	☐
Coronary Artery Disease	☐	☐	Osteoporosis	☐	☐
Depression	☐	☐	Seizures	☐	☐
Diabetes Miletus	☐	☐	Stroke	☐	☐
Diverticulitis	☐	☐	Tuberculosis	☐	☐

Additional Comments:

_____

_____

_____

Preventative Care

Have you had any of the following testing done? When?

Screening	Date (approximate if unknown)
☐ Blood Work	_____
☐ Mammogram	_____
☐ Pap Test	_____
☐ Colorectal Screening (FIT Test, Colonoscopy)	_____
☐ Other	_____

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Social History

Marital Status

☐ Single ☐ Married ☐ Common Law ☐ Divorced ☐ Widowed

Smoking History

Do you smoke cigarettes? ■ Yes ☐ No ☐ Quit

If yes, how many per day? _____

When did you start? _____

Former smoker? When did you quit? _____

How long did you smoke for? _____

Lifestyle

How would you rate your diet?	☐ Poor	☐ Fair	☐ Healthy
How often do you exercise?	☐ Sometimes	☐ Often	☐ Frequently
Do you drink alcohol?	☐ Yes	☐ No	# Per week_____
Do you use drugs/substances	☐ Yes	☐ No	
If yes, which substance?	☐ Marijuana	☐ Cocaine	☐ Heroine
	☐ Other		

Comments:_____

_____

_____

Any other concerns you would like your health care provider to know?

_____

_____

_____

_____

Information collected is to provide you with the best possible care. If you prefer to discuss a part of this form in person, please leave that section blank. This information will not be shared outside your circle of care without consent, unless legally required, nor will it be used to determine patient eligibility.

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SOCIO-DEMOGRAPHIC FORM – PART 1

Information collected will be used to identify who we serve in the community, and to promote equitable care. Equitable care incorporates unique needs that people may have based on language, income, gender, etc. Data collected is confidential and you may "prefer not to answer" for any question. If you choose to not answer, your care or access to services will not be affected. You can read more about our privacy policy on our website. www.windsorfht.ca

Full Name: _____

If you are a parent or a caregiver, please seek the consent of your child's or youth's approval before submitting this form. Please respond with "Prefer not to answer", if you have not received consent especially when answering gender and sexual orientation questions.
Thank you.

**For more information about consent please see: https://www.ipc.on.ca/part-x-cyfsa/consent-and-capacity/substitute-decision-makers/substitute-decision-makers-for-children-under-the-age-of-16/*

Please select the answers that best apply to you:

Age Range

- ☐ Under 18
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65+
- ☐ Prefer not to answer

Language

What language would you feel most comfortable speaking in with your healthcare provider?

- ☐ English
- ☐ French/Francophone
- ☐ Arabic
- ☐ Italian
- ☐ Spanish
- ☐ Other: _____
- ☐ Prefer not to answer

Were you born in Canada?

- ☐ Yes
- ☐ No
- ☐ Do not know
- ☐ Prefer not to answer

If NO, I have lived here for…

- ☐ Less than 1 year
- ☐ 1-3 years
- ☐ 4-10 years
- ☐ 10+ years
- ☐ Prefer not to answer

What is your race/ethnicity?

- ☐ Asian-East (Chinese, Japanese, Korean)
- ☐ Asian-South (Indian, Pakistani, Sri Lankan)
- ☐ Asian-South East (Malaysian, Filipino, Vietnamese)
- ☐ Black-African (Ghanaian, Kenyan, Somali)
- ☐ Black-Caribbean (Barbadian, Jamaican)
- ☐ Black-North American (Canadian, American)
- ☐ Indian-Caribbean (Guyanese with origins in India)
- ☐ Latin/Central America (Argentinian, Chilean, Salvadoran)
- ☐ Middle Eastern/West Asian (Egyptian, Iranian, Lebanese)
- ☐ White-European (English, Italian, Portuguese, Russian)
- ☐ White-North American (Canadian American)
- ☐ First Nations
- ☐ Indigenous/Aboriginal
- ☐ Inuit
- ☐ Metis
- ☐ Oceania
- ☐ Other _____
- ☐ Unknown
- ☐ Prefer not to answer

Do you have any of the following disabilities? (Check all that apply)

- ☐ Chronic Pain
- ☐ Chronic Illness
- ☐ Degenerative Disease
- ☐ None
- ☐ Developmental
- ☐ Learning Disability
- ☐ Physical Disability
- ☐ Do not know
- ☐ Mental Illness
- ☐ Drug/Alcohol Dependence
- ☐ Sensory (Vision/Hearing)
- ☐ Prefer not to answer
- ☐ Other: _____

How would you describe your gender?

- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Gender Fluid
- ☐ Two-Spirit
- ☐ Non-Binary
- ☐ Do not know
- ☐ Other: _____
- ☐ Prefer not to answer

☐ I would like to be connected with LGBTQ+ resources in the community.

What are your preferred pronouns?

- ☐ He/Him
- ☐ She/Her
- ☐ They/Them
- ☐ Do Not Know
- ☐ Other (please specify): _____
- ☐ Prefer not to answer

These questions are included to allow children and youth the opportunity to voluntarily and consensually self-identify their current lived gender identity. At any time, a child or youth may request a correction to their identity-based data.

What is your sexual orientation?

- ☐ Straight
- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Asexual
- ☐ Two-Spirit
- ☐ Queer
- ☐ Do not know
- ☐ Other: _____
- ☐ Prefer not to answer

This question is included to allow children and youth the opportunity to voluntarily and consensually self-identify their current sexual orientation. At any time, a child or youth may request a correction to their identity-based data.

What was your total household income before taxes last year?

**If you are under 18 years old, this question refers to the household income supporting you.*

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

How many people does this income support? _____

- ☐ Do not know
- ☐ Prefer not to answer

Do you have difficulty making ends meet with this income?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Unknown
- ☐ Prefer not to answer

Based on your answers, would you like to be connected to community resources?

- ☐ Yes
- ☐ No

Thank you for your participation. Your feedback helps us serve you better.

Ontario

SOCIO-DEMOGRAPHIC FORM – PART 2

Information collected will be used to identify who we serve in the community, and to promote equitable care. Equitable care incorporates unique needs that people may have based on language, income, gender, etc. Data collected is confidential and you may "prefer not to answer" for any question. If you choose to not answer, your care or access to services will not be affected. You can read more about our privacy policy on our website. www.windsorfht.ca

Full Name: _____

In what language would you prefer to read healthcare information? Please check one only.

- ☐ English
- ☐ French
- ☐ Amharic
- ☐ Arabic
- ☐ Bengali
- ☐ Braille
- ☐ Chinese (Simplified)
- ☐ Chinese (Traditional)
- ☐ Czech
- ☐ Dari
- ☐ Farsi
- ☐ Greek
- ☐ Hindi
- ☐ Hungarian
- ☐ Italian
- ☐ Karen
- ☐ Korean
- ☐ Nepali
- ☐ Polish
- ☐ Portuguese
- ☐ Punjabi
- ☐ Russian
- ☐ Serbian
- ☐ Slovak
- ☐ Somali
- ☐ Spanish
- ☐ Tagalog
- ☐ Tamil
- ☐ Tigrinya
- ☐ Turkish
- ☐ Twi
- ☐ Ukrainian
- ☐ Urdu
- ☐ Vietnamese
- ☐ Other (Specify) _____
- ☐ Not Applicable
- ☐ Do not know
- ☐ Prefer not to answer

What is your religious or spiritual affiliation? Please check one only.

- ☐ Agnosticism
- ☐ Animism or Shamanism
- ☐ Atheism
- ☐ Baha' I Faith
- ☐ Buddhism
- ☐ Christian Orthodox
- ☐ Christian, not included elsewhere on this list
- ☐ Confucianism
- ☐ Hinduism
- ☐ Islam
- ☐ Jainism
- ☐ Judaism
- ☐ Native Spirituality
- ☐ Pagan
- ☐ Protestant
- ☐ Rastafarianism
- ☐ Roman Catholic
- ☐ Sikhism
- ☐ Spiritual
- ☐ Unitarianism
- ☐ Zoroastrianism
- ☐ Other (Specify) _____
- ☐ Not Applicable
- ☐ Do not know
- ☐ Prefer not to answer

Religious and spiritual beliefs can influence healthcare decisions, end-of-life choices, and coping strategies. Collecting this data allows healthcare providers to offer culturally sensitive care that respects our patients' values.

What was your sex assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Prefer not to answer
- ☐ Do not know

This information allows us to better understand our patient demographics and health screenings.

Access to Communication Technologies

Do you currently have consistent access to a phone or the internet?

- ☐ Yes, phone only
- ☐ Yes, internet only
- ☐ Yes, both phone and internet
- ☐ No
- ☐ Do not know
- ☐ Prefer not to answer

Access to communication tools is important for staying connected to healthcare providers, scheduling appointments, and accessing health information. Collecting this data can help our team address potential barriers to communication.

Access to Medications and Medical Supplies

In the past 12 months, were you unable to get medicine or medical supplies, or did you do anything to make them last longer because of the cost?

- ☐ Yes
- ☐ No
- ☐ Not applicable, I did not have to get any medicine or medical supplies in the past 12 months
- ☐ Do not know
- ☐ Prefer not to answer

Being able to access and use needed medicine and medical supplies can affect your health. Your provider may use this to refer you to resources that can help you access medicine or medical supplies.

Food Security

Please indicate how applicable each statement is to you by selecting the option that best describes your situation.

Within the past 12 months, we worried whether our food would run out before we could buy or get more:

- ☐ Often True
- ☐ Sometimes True
- ☐ Never True
- ☐ Do not know
- ☐ Prefer not to answer

Within the past 12 months, the food we bought just did not last and we could not buy or get more:

- ☐ Often True
- ☐ Sometimes True
- ☐ Never True
- ☐ Do not know
- ☐ Prefer not to answer

By understanding food security challenges, we aim to offer interventions and referrals that address food insecurity and promote your overall well-being.

Housing Situation

What is your current housing situation?

- ☐ A place you or your family owns
- ☐ A place you or your family rents
- ☐ Social housing, Subsidized housing or Rent -geared -to - income
- ☐ Supportive housing or Group Home
- ☐ Long -term care facility
- ☐ Correctional facility
- ☐ Staying in someone else's place because you have no alternative
- ☐ Experiencing homelessness (e.g., shelter, living in a public place or vehicle)
- ☐ Other (Please specify) _____.
- ☐ Do not know
- ☐ Prefer not to answer

Housing stability significantly impacts overall well-being and access to healthcare. By collecting housing data, healthcare providers can identify housing-related challenges and address potential barriers that may affect patients' health and healthcare decisions.

Who do you live with? Select all that apply:

- ☐ Parent(s) or Guardian(s)
- ☐ Spouse or Partner
- ☐ Child(ren)
- ☐ Grandparent (s)
- ☐ Sibling(s)
- ☐ Other family
- ☐ Friends or Roommates
- ☐ Paid caregiver or attendant
- ☐ Alone
- ☐ Other (Please specify) _____.
- ☐ Prefer not to answer

In the past 12 months, was there a time when you were not able to pay the mortgage or rent on time?

- ☐ Yes
- ☐ No
- ☐ Not applicable. I did not have to pay rent or mortgage
- ☐ Do not know
- ☐ Prefer not to answer

Social Supports

Do you feel you have people who you can open up to or confide in?

- ☐ Yes, I always or sometimes have someone
- ☐ No, I don't have anyone
- ☐ Do not know
- ☐ Prefer not to answer

Do you have people to rely on if you needed help?

- ☐ Yes, I always or sometimes have someone
- ☐ No, I don't have anyone
- ☐ Do not know
- ☐ Prefer not to answer

Emotional support plays a critical role in mental health and overall well-being. Understanding our patients' confidants can help healthcare providers acknowledge existing support systems and provide tailored care that considers patients' social and emotional needs.

Access to Transportation

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Please select all that apply.

- ☐ Yes, it has kept me from medical appointments or getting medicines
- ☐ Yes, it has kept me from non - medical meetings, appointments, work, or getting things that I need
- ☐ No
- ☐ Not applicable, I did not need transportation for these activities in the past 12 months
- ☐ Do not know
- ☐ Prefer not to answer

Access to transportation can help or hinder patients' access to healthcare services and important activities, impacting their overall health and well-being. Recognizing these barriers allows healthcare providers to offer solutions and ensure patients receive the care they need.

Employment Status

Are you currently employed (this includes self-employed, full-time, part-time or other)?

- ☐ Yes
- ☐ No
- ☐ Do not know
- ☐ Prefer not to answer

Are you currently looking for work?

- ☐ Yes
- ☐ No
- ☐ Do not know
- ☐ Prefer not to answer

Is your main job temporary or part-time (e.g., casual, contract, freelance, short-term, seasonal)?

- ☐ Yes
- ☐ No
- ☐ Do not know
- ☐ Prefer not to answer

In the past 12 months, did your income change a lot from month to month?

- ☐ Yes
- ☐ No
- ☐ Do not know
- ☐ Prefer not to answer

Employment status can influence financial security, access to healthcare benefits, and the ability to seek medical care. Gathering this information may help our team understand patients' potential financial stressors and any barriers to accessing healthcare services.

Access to Utilities

In the past 12 months, did you miss making a payment on any utility bills (e.g., electric, gas/oil, water) because of cost?

- ☐ Yes
- ☐ No
- ☐ Do not know
- ☐ Prefer not to answer
- ☐ Not applicable, I did not have to pay utility bills in the past 12 months or utilities already included in rent

Access to essential utilities—such as water, electricity, and gas—is important for maintaining overall well-being and health. This information allows our team to better understand the social factors impacting our patients' lives. If you or someone you know needs assistance, please visit the Low-Income Energy Assistance Program for support: https://www.oeb.ca/consumer-information-and-protection/bill-assistance-programs/low-income-energy-assistance-program

Thank you for your participation. Your feedback helps us serve you better.

Ontario