

**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 family doctor identified in Section 4**

Last Name		First Name		Second Name	
Health Number		Version Code	Mailing Address ▶	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery
Date of Birth (yyyy/mm/dd)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town	Postal Code
Send notices from my family doctor's office to me by: <input type="checkbox"/> regular mail <input type="checkbox"/> email (if possible)			Residence Address ▶ or same as mailing address <input type="checkbox"/>	Apartment #	Street No. and Name or Lot, Concession and Township
Email Address:				City/Town	Postal Code

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

Last Name		First Name		Second Name	
Health Number		Version Code	Mailing Address ▶ or same as Section 1 <input type="checkbox"/>	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery
Date of Birth (yyyy/mm/dd)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town	Postal Code
I am this person's <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney for personal care			Residence Address ▶ or same as Section 1 <input type="checkbox"/>	Apartment #	Street No. and Name or Lot, Concession and Township
				City/Town	Postal Code

  

Last Name		First Name		Second Name	
Health Number		Version Code	Mailing Address ▶ or same as Section 1 <input type="checkbox"/>	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery
Date of Birth (yyyy/mm/dd)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town	Postal Code
I am this person's <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney for personal care			Residence Address ▶ or same as Section 1 <input type="checkbox"/>	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 and me.

I am signing on behalf of (check all that apply)

 myself  child(ren)  dependent adult(s)

My Name \_\_\_\_\_

Signature \_\_\_\_\_ Date (yyyy/mm/dd) \_\_\_\_\_

Home Telephone No. \_\_\_\_\_ Work Telephone No. \_\_\_\_\_

( ) ( )

**Section 4 – Family doctor information**

**DR. ALEXANDER SERBANESCU**  
**HARBOURFRONT APPLETREE CLINIC**  
**8 YORK STREET**  
**UNIT #4**  
**TORONTO, ON M5J 2Y2**

**BILLING NO. 042471 GROUP NO. FXDX**

(Include Billing no. and Group no.)

Family Doctor's Signature \_\_\_\_\_ Date (yyyy/mm/dd) \_\_\_\_\_

X