UWO Staff/Faculty Family Practice Clinic
RM 25, UCC Building

Patient Application and Registration Form

*Be sure to fill out a form for each eligible immediate family member (self, spouse, and child)

Surname:_____ First Name:_____ Initial:_____

Address: Street and Number: _____

City and Province: _____

Postal Code:_____

Home Telephone: _____ Cell Number:_____

Date of Birth (dd/mm/yy): _____ Sex: Male:____ Female:____

Billing Type: (example OHIP): OHIP _____ Bill Direct _____ UHIP _____ Other _____

Provincial Health Insurance ID: _____

E-mail address: _____

Work Telephone: _____

Department Name & Address: _____

_____

* May we communicate with you when needed at this e-mail address? Yes ____ No ____

Emergency Contact: Please provide a name, telephone number and the persons relationship to you (i.e. husband, wife, friend)_____

_____

If you work at UWO are you: Fulltime: _____ Part time:_____ Contract: _____

Do you currently have a physician in Ontario: Yes ____ No: ____

Name of Physician:_____

Physician's Address: _____

* When you have completed this form, please bring it to RM 25, UCC Building.