# PATIENT INFORMATION FORM

***PLEASE PRINT CLEARLY***

***COMPLETE ONE FORM FOR EACH FAMILY MEMBER***

**ARBOUR FAMILY MEDICAL CENTRE**
**281 STONE ROAD EAST, GUELPH, ON N1G 5J5 519-823-5133**

**Please note: Information herein will be shared amongst all Physicians and Nurse Practitioners who are accepting patients.**
**At present, we have a limited ability to take on new patients. This status fluctuates from week to week, and we will contact you if we are able to accommodate you/your family. Please do not contact our office regarding this application. Because of the number of forms received, it will not be possible to contact everyone. If you have not been contacted by this office within 3 months, it means we are not accepting new patients and this form will be destroyed in keeping with the Personal Health Information Protection Act.**

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|---|---|---|
| PATIENT NAME: | | |
| *NAME AS IT APPEARS ON HEALTH CARD IF DIFFERENT FROM ABOVE:* | | |
| ADDRESS: | | EMAIL ADDRESS: |
| POSTAL CODE | HOME PHONE incl area code | CELL/BUSINESS PHONE incl area code |
| DATE OF BIRTH:<br>DAY: _____ MONTH: _____ YEAR: _____ | | M____ F_____ |
| HEALTH CARD NUMBER: _____ VERSION CODE: __ __<br>EXPIRY:_____ | | |
| EMERGENCY CONTACT: (Name, Relationship, Phone)<br>_____ | | |
| Name of last Doctor / Practitioner:_____<br>Address: _____ | | |
| Date of Last Visit: _____ | | |
| List medical problems: (this is optional, and will not be used as a screening tool) | | |
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| Current medications: | | |
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| | | |
| Allergies: | | |
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Date:_____ Signature:_____