

FOR OFFICE USE ONLY

Date Reviewed:

Notes:

Score:

Nurse Practitioner:

New Patient Information

Date Submitted:

**Name
(First/Last):**

**Date of Birth
(dd/mm/year):**

Gender:

**Ontario Health Card #
and Expiry Date**

Address:

**City/Town/
Postal Code:**

Phone:

E-mail:

**Source of Income
(Employment/
Pension/ Social
Assistance:**

**Health Benefit
Provider (Ontario
Drug Benefits/
Private Insurance/
None):**

Please Check the Appropriate Response:

I do not have a Primary Care Provider

**I have a Primary Care Provider, but am unable to access care.
Provide a brief explanation (distance to provider, transportation...)**

New Patient Information Continued

Brief Health History:

Please list any chronic health conditions that you are currently being treated for:

Chronic Health Condition: <i>(Arthritis of both hips)</i>	Treatments/Therapies: <i>(Physiotherapy once weekly, swimming twice weekly)</i>	Medication and Dosage: <i>(Naproxen 500 mg twice daily)</i>	Medication Prescriber: <i>(Dr. Smith)</i>

Provide additional information you believe is important to share (please note - A full health history will be completed at your intake appointment with a Nurse Practitioner)

Please carefully review the following information and sign below.

- I acknowledge that the information provided on this form is correct to the best of my knowledge.
- I acknowledge that completing this registration form does not guarantee that I will become a patient of the Ingersoll Nurse Practitioner Led Clinic.
- I acknowledge that I am not a registered patient until AFTER the intake process is completed with a Nurse Practitioner.

Please mail or drop off in locked mail box:

**Ingersoll Nurse Practitioner Led-Clinic
19 King Street East
Ingersoll, ON N5C 1G3**

Attn: Clinical Director

Signature of Patient / Parent or Guardian