Dilico
Anishinabek Family Care

FAMILY HEALTH TEAM
NEW PATIENT REGISTRATION FORM

NOTE: *APPLICATION WILL NOT BE ACCEPTED IF ENTIRE FORM IS NOT COMPLETED*

DATE: ____

SURNAME: ____

FIRST NAME: ____

BIRTH DATE:_____________/_____________/_____________ Gender Identity ____________________
Day Month Year

ADDRESS: ____

CITY:______________________________POSTAL CODE:______________________________

PHONE: (Home) ________________________ (Alternate) ______________________________

HEALTH CARD #: __________________________ Version Code ______ Expiry Date: ________

ALLERGIES: ____

NAME OF PARENT/GUARDIAN: ______________________DOB: ________________________
(Applicable to children under 18 years of age)

Do you currently have a primary care provider (Doctor/Nurse Practitioner): Yes ☐ No ☐

Who is/was your primary care provider (Doctor/Nurse Practitioner): ________________________

Address of Primary Care Provider: ____
(Include city and Postal code)

When did you last see them? ____

Where have you been receiving your health care? ______________________________________

Optional: Are you: Status ☐ Non Status ☐ Métis ☐

Status # ______________________________________ Band: ______________________________

Primary Language: English ☐ Ojibway ☐ Cree ☐ Ojicree ☐ Other:____________________

PLEASE PROVIDE A PRESCRIPTION SUMMARY FROM YOUR PHARMACY

PLEASE PROVIDE A SUMMARY OF YOUR CURRENT MEDICAL HISTORY