Purkinje File No.	Date Received

Port Hope Community Health Centre

CLIENT INFORMATION/REGISTRATION FORM

I understand that my information will only be collected, used and disclosed for the purpose of assessing my eligibility, and if eligible, to provide me with, and coordinate health services and programs by The Port Hope Community Health Centre and any organization authorized by the Centre, in a manner consistent with the Centre's Privacy Policy.

Name:________________________, ________________________ Last First	Gender: ❑ Male ❑ Female
Health Card Number:______________ Version: ______Expiry: ________	Date of Birth: _____/_____/_____ mm dd yy
Address: ____________ ________ ____________ ____________ Street Apt. City/Town Postal Code	
Phone: ( ) ____________Business: ( ) ____________Cell: ( ) ____________	
Emergency Contact: ____________ Phone ( ) ____________	
Preferred Language: English French Other (specify):	

Who is your current family doctor?

Where is he/she located?

Are you pregnant? ❑ no ❑ yes - expected due date?

Allergies (list any known)

Drugs	Environmental/food

Current Medications

Medication	Dosage	How often?	Medication	Dosage	How often?

Medical History

Current Illness	Year of diagnosis	Past surgery(s)	Year

OVER

CURRENT HOUSEHOLD COMPOSITION:

- ❑ Sole member
- ❑ Single parent family (mother head)
- ❑ Single parent family (father head)
- ❑ Grandparents with grandchildren
- ❑ Couple without children
- ❑ Extended family
- ❑ Mother, father, child(ren)
- ❑ Siblings
- ❑ Unrelated housemates
- ❑ I prefer not to answer
- ❑ Other (specify):

BACKGROUND: (Information about your cultural/ethnic background will help us plan health services and programs for you):

COUNTRY OF ORIGIN: ________________________ NUMBER OF YEARS RESIDING IN CANADA:______
(If born outside of Canada)

EDUCATION: (Please check highest level completed)

- ❑ Primary or equivalent (grades 1-8)
- ❑ Secondary or equivalent (grades 9-12/13)
- ❑ College
- ❑ University
- ❑ No formal education
- ❑ I prefer not to answer
- ❑ Other (specify):

COMBINED ANNUAL HOUSEHOLD INCOME:

- ❑ 0 - $14,999
- ❑ $15,000 – $19,999
- ❑ $20,000 - $24,999
- ❑ $25,000 - $29,999
- ❑ $30,000 - $34,999
- ❑ $35,000 - $39,000
- ❑ $40,000 - $59,000
- ❑ Over $60,000
- ❑ Don’t know
- ❑ Prefer not to answer

Number of people supported by this income:______

If you are interested in receiving e-mail flyers of The Community Health Centre activities, please provide an e-mail address: ____

For Office Use Only
Doctor/Nurse Practitioner Documentation

For office use only

Provider: ________________________________ Group name: ________________________________

Data entered on: / / (month/day/year)

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