

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: _____, _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> Last First </div>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Health Card Number: _____ Version: _____ Expiry: _____	Date of Birth: _____/_____/_____ <div style="display: flex; justify-content: space-around; font-size: small;"> mm dd yy </div>
Address: _____ <div style="display: flex; justify-content: space-between; width: 90%; margin: 0 auto;"> Street Apt. City/Town Postal Code </div>	
Phone: () _____ Business: () _____ Cell: () _____	
Emergency Contact: _____ Phone () _____	
Preferred Language: English French Other (specify): _____	

Do you have a family doctor or nurse practitioner? <input type="checkbox"/> no <input type="checkbox"/> yes, where?					
Are you pregnant? <input type="checkbox"/> no <input type="checkbox"/> 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		

CURRENT HOUSEHOLD COMPOSITION:

- | | | |
|---|---|---|
| <input type="checkbox"/> Sole member | <input type="checkbox"/> Couple without children | <input type="checkbox"/> Unrelated housemates |
| <input type="checkbox"/> Single parent family (mother head) | <input type="checkbox"/> Extended family | <input type="checkbox"/> I prefer not to answer |
| <input type="checkbox"/> Single parent family (father head) | <input type="checkbox"/> Mother, father, child(ren) | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Grandparents with grandchildren | <input type="checkbox"/> Siblings | |

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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Primary or equivalent (grades 1-8) | <input type="checkbox"/> University | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Secondary or equivalent (grades 9-12/13) | <input type="checkbox"/> No formal education | |
| <input type="checkbox"/> College | <input type="checkbox"/> I prefer not to answer | |

COMBINED ANNUAL HOUSEHOLD INCOME:

- | | | |
|--|--|---|
| <input type="checkbox"/> 0 - \$14,999 | <input type="checkbox"/> \$30,000 - \$34,999 | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> \$15,000 - \$19,999 | <input type="checkbox"/> \$35,000 - \$39,000 | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> \$20,000 - \$24,999 | <input type="checkbox"/> \$40,000 - \$59,000 | |
| <input type="checkbox"/> \$25,000 - \$29,999 | <input type="checkbox"/> Over \$60,000 | |

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)