For Office Use Only	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 Initial
(As it appears on your Health Card)

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?
If you do not have a family doctor, who was your previous 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

Port Hope Community Health Centre
99 Toronto Rd, Port Hope, ON, L1A 3S4
T: 905-885-2626 F: 905-885-2646

OVER

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)

Filling out this form helps us to determine if you can have services here. Providing any false information will mean you may not be eligible to be a client at this centre.

Client Signature: _____ Date:_____

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Port Hope Community Health Centre

Authorization to Collect, Use and Disclose Personal health Information

The CHC needs your consent in order to collect, use and share your personal health information with healthcare organizations, physicians and healthcare professionals involved in your care as well as to anyone you identify as a contact . Your information is private and confidential. Unless sharing is permitted by law, the CHC will not give out any of your information without your consent. Information collected on this authorized form complies with the Privacy Act and the Personal Health Information Protection Act (2004) (PHIPA).

The purpose for the collection of this information is to determine eligibility for

- determining your needs and coordinate the services that can be provided to you
- reviewing your needs and services on an ongoing basis
- directly or indirectly providing you with health and related social services
- monitoring the quality of services you are receiving
- planning and evaluation of services
- purposes permitted by law

In addition, information - your name, address and phone number - may be used to carry out client satisfaction surveys. It will be given to an external third-party agency we have contracted to carry out these surveys. Your signature will indicate your consent to the CHC using and disclosing this information.
Please discuss any questions with your healthcare provider or contact the Privacy Officer at the CHC for more information. As a CHC client you have the right to refuse to consent, or to withdraw your consent at any time by contacting your care provider.

Do you have any questions or concerns? Do you understand and agree with all that we have discussed?

Name (please print)_____

Signature_____

Legal Guardian (if applicable); _____

Date _____

January 3, 2011