Simcoe Medical Clinic
FAMILY & WALK-IN CARE Central Oshawa

115 Simcoe St. South, Oshawa, ON L1H 4G7
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New Patient Registration Form

Welcome to Simcoe Medical Clinic. Please complete all sections below. You can type directly into this PDF and print it, or print it first and fill it in by hand. Bring it to your first appointment along with your health card and a piece of photo identification.

1 PATIENT INFORMATION

Last name

First name

Date of birth (DD / MM / YYYY)

Sex
☐ Male ☐ Female ☐ Other

Ontario health card number

Version

Street address

City

Province

Postal code

Home phone

Cell phone

Email address

Preferred contact method
☐ Phone ☐ Email ☐ Text

Preferred language

Interpreter needed
☐ No ☐ Yes

2 YOUR CARE PREFERENCES

Doctor preference (you can change this at any time)
☐ No preference ☐ Male doctor ☐ Female doctor

Pharmacy
☐ Use Oshawa People Pharmacy, located inside the clinic, for my prescriptions

If you prefer a different pharmacy, please name it

3 EMERGENCY CONTACT

Full name

Relationship to you

Phone number

4 MEDICAL HISTORY

Please list as much as you can. Write "none" where it does not apply.

Allergies (medications, foods, latex, other) and the reaction

Current medications and supplements, with dosage

Ongoing medical conditions

Past surgeries or hospital stays, with year

Family medical history (parents, siblings)

5 LIFESTYLE (OPTIONAL)

Do you smoke or vape?

☐ Never ☐ Former ☐ Current

Alcohol use

☐ None ☐ Occasional ☐ Regular

6 CONSENT AND SIGNATURE

I confirm that the information I have provided is accurate and complete to the best of my knowledge. I consent to receive care from the physicians and staff at Simcoe Medical Clinic. I understand that my personal health information will be collected, used, and disclosed to provide my care and to operate the clinic, in keeping with Ontario's Personal Health Information Protection Act (PHIPA).

☐ I consent to receive appointment reminders and clinic communication by phone, email, or text message.

☐ I have read and understood the statement above and agree to its terms.

Signature of patient or parent / guardian

Date

FOR OFFICE USE ONLY

Date received

Chart number

Most responsible provider