



LEAMINGTON & AREA
Family Health Team

194 Talbot Street West
Leamington, ON N8H 1N0
PH: 519-322-1100 FAX: 519-322-2055
Attention: Rose Witcher

APPLICATION FORM

Date: _____ Sex: M ___ F ___
Name: _____ Birth Date: _____
Health Card # _____ Version code: _____
Phone #: _____ Address: _____
Town: _____ Postal Code: _____

Referred by: _____ Current/Last Physician: _____

Names of other family members interested in joining the Family Health Team:

Relationship: _____ Name: _____ DOB: _____
Relationship: _____ Name: _____ DOB: _____
Relationship: _____ Name: _____ DOB: _____
Relationship: _____ Name: _____ DOB: _____
Relationship: _____ Name: _____ DOB: _____

Any other information helpful, for example, surgeries, family histories etc:

Current Medication List:

OFFICE USE ONLY:

CONTACTED: _____ APPT: _____ CHART: _____
ROSTER FORM: _____ NEW PATIENT DECLARATION: _____ INFO: _____