

**FOUR COUNTIES MEDICAL CLINIC
NEW PATIENT APPLICATION FORM**

253A Main Street Glencoe, ON N0L 1M0
Phone: 519-287-2616 Fax: 519-287-5395

NAME: _____

DATE OF BIRTH: _____

STREET: _____ CITY: _____ POSTAL CODE: _____

HOME TELEPHONE #: _____ WORK TELEPHONE #: _____

HEALTH CARD #: _____ VERSION CODE: _____ EXP DATE: _____

Name of Previous Family Physician: _____

Date of Last Visit: _____

I do not currently have a physician for the following reason (please check):

- My Family Physician moved
- My Family Physician has retired
- My Family Physician is not available due to death/illness
- I have moved to another community
- I have not had a family physician

If you have not checked any of the above options, please describe your reason for looking for a new physician: _____

Would you like to register your spouse/children? ____ Yes ____ No

If yes, please list all family members that live at the same address below:

Name	Date of Birth (dd/mm/yyyy)	Health Card #	Version Code

Medical Problems:

Name	List of Medical Problems

Current Medication:

Name	List of Current Medication

Signature: _____

Date: _____