UWO Staff/Faculty Family Practice Clinic
RM 25, UCC Building

Patient Application and Registration Form

*Be sure to fill out a form for each eligible immediate family member (self, spouse, and child)

Surname:_____ First Name:_____ Initial:_____

Address: Street and Number: _____

City and Province: _____

Postal Code:_____

Home Telephone: _____ Cell Number:_____

Date of Birth (dd/mm/yy): _____ Sex: M ◯ F ◯ Non-binary ◯

Billing Type: (example OHIP): OHIP ◯ Bill Direct ◯ UHIP ◯ Other ◯

Provincial Health Insurance ID: _____

E-mail address: _____

Work Telephone: _____

Department Name & Address: _____

_____

*May we communicate with you when needed at this e-mail address? Yes ◯ No ◯

Emergency Contact: Please provide a name, telephone number and the persons relationship to you (i.e. husband, wife, friend)_____

_____

If you work at UWO are you: Full-time ◯ Part-time ◯ Contract ◯

**Contract must be at least 1 year in length.

Do you currently have a physician in Ontario: Yes ◯ No ◯

Name of Physician:_____

Physician's Address: _____

*When you have completed this form, please mail to RM 25, UCC Building or fax to 519-661-3824 or email to fpclinic@uwo.ca.