New Patient Application Sylvia Lee MD

Chancellors Way Medical Arts Centre

PLEASE PRINT CLEARLY **Today's Date:** ______________
mm / dd / yyyy

Patient Name:

First ______________________________ Last ______________________________

Name as it appears on healthcard *(if different from above)*:

First ______________________________ Last ______________________________

Address: ____

City: ____________________________ Postal Code: ______________________

Home # *(w/area code)*: ________________________ Mobile #: ___________________________

Date of Birth: ________________________ Gender *(circle)*: M F X
mm / dd / yyyy

Healthcard #: ______________________________

Expiry *(if applicable)*: ________________ Version Code (two letters): _______

Are you registering your spouse/children *(circle)*: YES NO If yes please fill below:

Name: ____ Date of Birth: ______________
mm / dd / yyyy

Healthcard #: ___________________________________ Gender *(circle)*: M F X

Expiry *(if applicable)*: ________________ Version Code (two letters): _______

Name: ____ Date of Birth: ______________
mm / dd / yyyy

Healthcard #: ___________________________________ Gender *(circle)*: M F X

Expiry *(if applicable)*: ________________ Version Code (two letters): _______

Name: ____ Date of Birth: ______________
mm / dd / yyyy

Healthcard #: ___________________________________ Gender *(circle)*: M F X

Expiry *(if applicable)*: ________________ Version Code (two letters): _______

Name: ____ Date of Birth: ______________
mm / dd / yyyy

Healthcard #: ___________________________________ Gender *(circle)*: M F X

Expiry *(if applicable)*: ________________ Version Code (two letters): _______

Please turn over

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Name of last family physician:

_____

Address: _____

Date of last visit: _____

Please list medical problems:

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Allergies:

_____

_____

We can not accept applications by email.

Please drop your application off **IN PERSON** at CareWell Health Group:

CareWell Health Group

CareWell Health Group
175 Chancellors Way, Suite 102
Guelph Ontario N1G 0E9

Or you can **FAX** your application to **519-341-9254**