

December 2008

Dear Prospective Patient:

Thank you for your interest in the **Elmwood Family Health Centre**. We are two physicians who will be joining Dr. Kellie Scott at her new clinic in January 2009. We are looking forward to providing primary health care to St. Thomas and Elgin County residents. We will be accepting patients, who do not currently have a family doctor, beginning in the New Year.

If you are interested in becoming a patient, please follow the steps outlined below:

1. Complete, date, and sign reverse side of this form
2. Fill out separate forms for each family member and return the forms as a group
3. Mail the completed form(s) to:

**Dr. Melissa A. Johnson and Dr. W. Paul Fox
P.O. Box 22112
RPO Elmwood Sq
St. Thomas, ON
N5R 6A1**

INFORMATION SHEETS WILL NOT BE ACCEPTED IN PERSON AT THE CLINIC.

DUE TO THE SHORTAGE OF FAMILY DOCTORS IN ST. THOMAS, WE WILL NOT BE ABLE TO ACCEPT ALL RESPONDENTS AS PATIENTS. INCOMPLETE FORMS WILL BE DISCARDED.

Once we begin our practice you *may* be contacted at the phone number provided on the Information Sheet to schedule an initial consultation.

If you require medical care before being contacted, please go to:

St. Thomas Walk-In Medical Clinic
105-230 First Avenue
St. Thomas, ON
(519) 633-9627

Sincerely,

Melissa A. Johnson M.D., C.C.F.P.
W. Paul Fox M.D., C.C.F.P.

NEW PATIENT INFORMATION SHEET

CONFIDENTIAL WHEN COMPLETED. PLEASE PRINT CLEARLY.

LAST NAME						FIRST NAME										
ADDRESS																
CITY/TOWN						POSTAL CODE										
HOME PHONE					OTHER PHONE					EMAIL						
DATE OF BIRTH		DD		MM		YYYY				MALE			FEMALE			
HEALTH CARD NUMBER (INCLUDING LETTERS AFTER THE NUMBER)								EXPIRY DATE (ON BACK OF GREEN CARDS ONLY)								
DO YOU CURRENTLY HAVE A FAMILY PHYSICIAN?				__ YES __ NO			CITY					DATE LAST SEEN				
				Name _____												
PLEASE INDICATE WHICH PHYSICIAN YOU WOULD LIKE TO APPLY TO				<input type="checkbox"/> Dr. Melissa A. Johnson <input type="checkbox"/> Either <input type="checkbox"/> Dr. W. Paul Fox												
PLEASE LIST PREVIOUS SURGERIES																
PLEASE LIST MEDICAL AND/OR PSYCHIATRIC PROBLEMS (PAST AND PRESENT)																
PLEASE LIST ALL CURRENT MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER)																
PLEASE LIST ANY ALLERGIES																
PLEASE LIST OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CARE (SPECIALISTS, NATUROPATHS, CHIROPRACTORS ETC.)																

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE:

PROSPECTIVE PATIENT'S (OR GUARDIAN'S) SIGNATURE

DATE