

Southwest Ontario Aboriginal Health Access Centre "Application Form"

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: (Day/Mon/Yr) \_\_\_\_\_

Address: \_\_\_\_\_

City/Town/First Nation: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ if no phone, where can we leave a message? \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Version code (2 letters at the end of the #) \_\_\_\_\_

Status Number \_\_\_\_\_ Name of First Nation \_\_\_\_\_

Do you presently have a Family Doctor? yes \_\_\_ no \_\_\_ Doctor's name: \_\_\_\_\_

If yes, please indicate reason for seeking new Primary Care? \_\_\_\_\_

Other family members who see Doctors or Nurse Practitioners at SOAHAC

Name	Relationship

Medical Conditions: Please check off all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Pregnancy                 | <input type="checkbox"/> Newborn or Infant under 2 years old  |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart disease (heart attack, angina) |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Asthma or lung disease               |
| <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Seizures/Epilepsy                    |
| <input type="checkbox"/> Cancer – what kind? _____ | <input type="checkbox"/> Depression or mental health issues   |

other serious medical or other conditions not listed above (please explain)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications:** Please list all medication you are currently taking: (add additional sheet if needed)


Signature: \_\_\_\_\_ Date: \_\_\_\_\_