Carea Community Health Centre
Care. Compassion. Community.

☐ Medical / Counselling Client
☐ IPC Client
☐ GAIN Client
☐ HPCDS Program:
☐ HEP C Client
☐ DEP Client

Client Registration Form

Today's date: _____

CLIENT / PARTICIPANT INFORMATION

Last Name:		**Birth Date:** DD – MM - YYYY
First Name:	**Preferred Name:**	**Middle Name:**

Gender on Birth Certificate: ☐ Male ☐ Female

Address:			**No Fixed Address:** □ Living in Shelter □ Living on the street □ Other (i.e. Home of friend)
City:	**Province:**	**Postal Code:**	

Primary Phone #:	**Alternate Phone #:**

Email Address:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common Law ☐ Separated ☐ Other (Please Specify): _____ ☐ Unknown

Preferred Language: ☐ English ☐ French ☐ Other (Please Specify):

Allergies:

What is your religion? ☐ Anglican ☐ Buddhist ☐ Catholic ☐ Christian ☐ Hindu ☐ Jewish ☐ Jehovah's Witness ☐ Muslim ☐ Protestant ☐ Sikh ☐ None ☐ Other (please specify): _____ ☐ Prefer not to answer

Citizenship: ☐ Canadian ☐ Landed Immigrant ☐ Refugee ☐ Indigenous ☐ Refugee Claimant ☐ Government Assisted Refugee ☐ Private Sponsored Refugee ☐ Other

Country of Birth:	**Arrival Date in Canada (if applicable):** DD – MM – YYYY

HEALTH CARD INFORMATION

Health Card #:	**Version Code:**
Exact Name on Health Card:	**Expiry Date:** DD – MM – YYYY

If you do not have a health card, why?

□ OHIP Eligible but no card (Lost Health Card)
□ No Insurance
□ Other Province (Name): _____
□ Interim Federal Health Program: # _____
□ 3 month wait period

REMINDER CALLS

Carea Community Health Centre may use an automated call system to remind you of appointments. The system will try contacting you within 24 to 48 hours of your booked appointment(s).
Do you consent to Carea calling or texting on your primary phone by our reminder system? ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT CAREA COMMUNITY HEALTH CENTRE?

☐ Referral: _____ ☐ Website ☐ Social Media ☐ Newspaper ☐ Other (Please Specify): _____

DEMOGRAPHIC INFORMATION

The Ministry of Health requires that we collect additional information about the clients we serve for its provincial wide evaluation project. Please fill in the following to the best of your ability. **This information should focus on the registered participant.**

What is your racial or ethnic group:

☐ Asian – East
☐ Asian – South
☐ Asian – South East
☐ Black – African
☐ Black – Caribbean
☐ Black – North American
☐ First Nations
☐ Indian – Caribbean
☐ Indigenous / Aboriginal
☐ Inuit
☐ Latin American
☐ Metis
☐ Middle Eastern
☐ White – European
☐ White – North American
☐ Mixed Heritage (Please Specify) _____
☐ Other (Please Specify) _____
☐ Do not know
☐ Do not wish to answer

DEMOGRAPHIC INFORMATION CONTINUED

Please indicate the highest level of education	Combined annual household income	Household composition
☐Too young for primary completion ☐ Primary (Grades 1 to 8) ☐ Secondary (Grades 9 to 12) ☐Post-Secondary or equivalent (University / College) ☐ No formal education ☐ Other: _____ ☐ Do not know ☐ Prefer not to answer	☐$0 - $14,999 ☐ $15,000 - $19,999 ☐ $20,000 - $24,999 ☐ $25,000 - $29,999 ☐ $30,000 - $34,999 ☐ $35,000 - $39,999 ☐ $40,000 - $59,999 ☐ $60,000 + ☐ Prefer not to answer How many people are supported by this income? _____	☐ Mother, father, child(ren) ☐ Couple without child(ren) ☐ Sole member ☐ Single parent family (father) ☐ Single parent family (mother) ☐ Grandparents with grandchild(ren) ☐ Siblings ☐ Same-sex couple with/without children ☐ Unrelated housemates ☐ Extended family ☐ Other: _____ ☐ Prefer not to answer

Do you have any of the following? Check ALL that apply:

☐ Chronic Illness (Diabetes, Heart Disease, etc.)
☐ Developmental Disability
☐ Drug or Alcohol Dependence
☐ Learning Disability
☐ Mental Illness
☐ Physical Disability
☐ Sensory Disability
☐ Other (please specify)
_____
☐ None
☐ Do not know
☐ Prefer not to answer

Gender Identity: ☐ Male ☐ Two-Spirit ☐ Intersex ☐ Trans- Female to Male ☐ Trans- Male to Female ☐ Female ☐ None ☐ Do not know ☐ Prefer not to answer ☐Other: _____

What is your sexual orientation? ☐ Bi-Sexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Queer ☐ Two-Spirit ☐Other: _____ ☐ Do not know ☐ Prefer not to answer

PARENT / GUARDIAN CONTACT INFORMATION (IF UNDER CLIENT UNDER 16)

Name:	Relationship to client:	
Address: ☐ Same as Above	Primary Phone:	Alternate Phone:

EMERGENCY CONTACT INFORMATION

Name:	Relationship to client:	
Address: ☐ Same as Above	Primary Phone:	Alternate Phone:

PHARMACY OF CHOICE

Pharmacy Name & Address	Phone #:

PRIVACY POLICY STATEMENT

We encourage you to review Carea Community Health Centre's Privacy Policy. Please read the following information regarding our privacy practices. Your privacy is very important to us at Carea Community Health Centre. The personal health information that you give us will be held and may be used and shared to make sure we are able to provide you with the best possible care.

Your personal health information will not be released to any person outside Carea Community Health Centre without your written or verbal consent, except under the following conditions:

- Where an individual appears to be a danger to themselves and others
- Where child abuse is suspected
- Where we are required by law, statute or regulation

You have the right to withdraw your consent or to limit the information that you give us. However, this may result in a change in the care that we provide.

I have read and understand the above privacy policy information.

Printed Name: _____ Signature: _____ _____ Date:_____

If you have any questions about Carea Community Health Centre's Privacy Policy please contact our Privacy Officer at 905-723-0036

Office Use Only:

Date Received: Staff entered by: Chart #: