CARENEST MEDICAL CENTER
114-101 Cherryhill Blvd, London, ON N6H 4S4
Phone: 226-289-7241

NEW FAMILY DOCTOR STARTING PRACTICE FROM JULY 2ND, 2026

NEW PATIENT APPLICATION FORM

(ONLY ONE FORM SHOULD BE COMPLETED PER PATIENT)

Last Name: _____**First Name**: _____
Health Card Number (with version code): _____ Expiry: Date (yyyy/mm/dd):_____
Date of Birth (yyyy/mm/dd): _____ Sex: _____
Home Address: _____
Phone number: _____Email: _____
Emergency Contact (Name, Relationship, Number): _____
Allergies (Please include the name of medication or food, type of reaction, and age of onset): _____
Previous Family Physician's Name: _____
Physician's Phone No: _____ Physician's Fax No:_____
Reason for changing Doctor: _____
Medical History: Please list the CONFIRMED Medical conditions. Write N/A if none:
_____
_____

Surgeries & Procedures: Please list any surgeries/procedures you have had in the past, including any miscarriages, abortions, or caesarean sections. Write N/A if none:
_____

Medication List: Please list any current medications that you are taking, including prescription medications, over the-counter medications, Vitamins and supplements. Write N/A if none.
_____
_____
_____

Social and Lifestyle History:
What is your occupation? _____
Alcohol use: Do you drink alcohol? NO YES
If yes, please mention Quantity & Frequency: _____
Cigarettes: Have you smoked cigarettes? NO YES Current (cigs/day): _____
Recreational Drug OR Substance Use? NO YES
if yes, please provide detail per use_____

Are you on ODSP, OW, Trillium Coverage? If yes, which one? _____
Any other information you'd like us know: _____

Patient/Guardian Signature: _____ **Date:** _____

The Completion of this form is not a guarantee of acceptance into a practice; at present there is no timeline for acceptance into a practice.