



### Registration Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: day \_\_\_\_ month \_\_\_\_ year \_\_\_\_\_ Gender:  Male  Female  
 Transgender:  M to F  F to M  
 Other (please specify) \_\_\_\_\_

Residence Address: \_\_\_\_\_  
*Number & Street Name City Province Postal Code*

Mailing Address: P.O. Box: \_\_\_\_\_ R.R. # \_\_\_\_\_  
*If different from above*

Telephone: Home ( \_ \_ \_ ) \_\_\_\_\_ Can we leave a message?  Yes  No  
Cell ( \_ \_ \_ ) \_\_\_\_\_ Can we leave a message?  Yes  No  
Work ( \_ \_ \_ ) \_\_\_\_\_ Ext \_\_\_\_\_ Alternate number ( \_ \_ \_ ) \_\_\_\_\_

Contact person in case of emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home ( \_ \_ \_ ) \_\_\_\_\_ Work ( \_ \_ \_ ) \_\_\_\_\_ Ext. \_\_\_\_\_ Cell ( \_ \_ \_ ) \_\_\_\_\_

Other Family contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home ( \_ \_ \_ ) \_\_\_\_\_ Work ( \_ \_ \_ ) \_\_\_\_\_ Ext. \_\_\_\_\_ Cell ( \_ \_ \_ ) \_\_\_\_\_

Health Card: \_\_\_\_\_ Version Code (letters): \_\_\_\_\_ Expiry Date: \_\_\_\_\_  
DD-MM-YYYY

What pharmacy do you use: \_\_\_\_\_ Location: \_\_\_\_\_

- I currently DO NOT have a doctor or nurse practitioner
- I currently have a doctor or nurse practitioner but I have difficulty accessing them due to transportation or mobility issues

I acknowledge and agree that the provision of personal health information by me constitutes my consent to its collection, use and limited disclosure by Seaway Valley Community Health Centre. I understand that the collection, use and limited disclosure of any personal health information will only be for the purposes of providing services and information to me by SVCHC or any organization authorized by SVCHC and only in a manner consistent with SVCHC's Privacy Policy. SVCHC complies with all legislation and other requirements of the Ministry of Health including Ontario's Personal Health Information Protection Policy (PHIPA).

Signature \_\_\_\_\_ Signature of Guardian \_\_\_\_\_ Date \_\_\_\_\_

## SOCIO-DEMOGRAPHIC INFORMATION

We know that many things affect our health. We understand that the questions we are asking are personal but your answers are important and will help us provide services and programs that meet the needs of our community. This information is used collectively. All questions are optional.

### ORIGIN / CULTURE

White     Black     Asian     Hispanic     Aboriginal     Other \_\_\_\_\_

Country of Birth:  Canada     Other \_\_\_\_\_    Year of Arrival \_\_\_\_\_  
DD-MM-YYYY

Do you need a translator?     Yes     No

Primary/Preferred Language     English     French     Other \_\_\_\_\_

### HOUSEHOLD COMPOSITION

**Please describe the composition of your household**

Couple                       Single parent – Mother                       Unrelated housemates  
 Couple with child(ren)     Single parent – Father                       Live with extended family  
 Live alone                       Grandparents with grandchildren                       Other: \_\_\_\_\_

**What is your total FAMILY income ? Check ONE only**

0 – 14,999                       30,000 – 34,999                       Doesn't know                       Prefer not to answer  
 15,000 – 19,999                       35,000 – 39,999  
 20,000 – 24,999                       40,000 – 59,999  
 25,000 – 29,999                       Over 60,000

**How many people does this income support?** \_\_\_\_\_

**What is the source of income for the APPLICANT?**

<b>Employed</b>	<b>Unemployed</b>	<b>Retired</b>	<input type="checkbox"/> Student	<input type="checkbox"/> None
<input type="checkbox"/> Full time	<input type="checkbox"/> Employment Insurance	<input type="checkbox"/> CPP/OAS		
<input type="checkbox"/> Part time	<input type="checkbox"/> Ontario Works	<input type="checkbox"/> Private Pension Plan		
<input type="checkbox"/> Self-employed	<input type="checkbox"/> ODSP			

### CURRENT OCCUPATION

**Please specify:** \_\_\_\_\_

### EDUCATION

If age 18 or older, please indicate your **highest level of education**

Primary School (JK to Gr. 8)     College                       No formal education  
 Secondary School (Gr. 9 to 12)     University                       Other \_\_\_\_\_

### FAMILY CHARACTERISTICS

Please indicate your current relationship status:

Single                       Married and/or living with a partner                       Married same sex and/or living with a partner  
 Separated                       Divorced                       Widowed                       Other \_\_\_\_\_

### SEXUAL ORIENTATION

Do you identify as:

Straight/heterosexual                       Gay                       Bisexual                       Lesbian  
 Other \_\_\_\_\_ (e.g. questioning, two-spirit)

### DISABILITY

Do you have any of the following?     NO                       YES                      (Check ALL that apply)

Chronic Illness                       Learning disability                       Sensory disability  
 Developmental disability                       Mental illness  
 Drug or alcohol dependence                       Physical disability                       Other \_\_\_\_\_