Lakehead
Nurse Practitioner-Led Clinic

Suite 101- 325 S. Archibald St.
Thunder Bay, ON, P7E 1G6
Tel: 807-475-9595
Fax: 807-475-9797

Client Registration Form

Forms may be submitted by fax, mail or in person

Surname: _____ Given Names: _____
Birth Date: (yyyy,mm,dd) _____
Health Card #: _____Version Code:_____Expiry:_____
Phone Number: (home)_____ (work)_____ (cell)_____
Address:_____
_____Postal Code:_____
Gender: ☐ Male ☐ Female Language(s):_____
Emergency Contact / Next of Kin:_____ Relationship:_____
Phone Number: (home)_____ (work)_____ (cell)_____
Address:_____

Please complete for all clients with a legal guardian, and for all children less than 16 years of age if different than above:
Primary Guardian: _____ Relationship: _____
Phone Number: (home)_____ (work)_____ (cell)_____
Address:_____

Allergies: _____
Pharmacy: (Name and Location) _____

Current and Past Medication (name, strength, frequency)	**Reason for Taking Medication** (Attach additional list if needed)
e.g., Tylenol 500mg, 3 times a day	*For arthritis pain*

In general, how would you describe your health: ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Are you currently under the care of any other primary care provider? ☐ YES ☐ NO

Please describe where you have been receiving health care over the last two years (please include the names and address of providers, clinics, and agencies if known):
_____
_____
_____
_____

Please briefly list your health concerns (please include a date your health concern started if known):
_____
_____
_____
_____
_____

Where did you hear about the Lakehead Nurse Practitioner-Led Clinic? _____

By signing below, you agree that there have been no omissions or misrepresentations regarding your health history or current treatments. Failure to properly disclose your health status may result in an inability for the Lakehead NP-Led Clinic to meet your health care needs.

Signature:_____ Date:_____