Dr. Sean Peterson

MD, BASc, CCFP(EM)

Second Floor (previous office of Dr. Chilvers)
481 London Road, Sarnia ON, N7T 4X3
P: 519-337-7512 F: 519-337-3257
Email: info@drpeterson.ca
Website: www.drpeterson.ca

Patient Application Form

*****Each member of a family must complete a registration form*****

Demographics

Last Name	**Given Names**
Date of Birth	**Age**
Gender	
Street Address	**Apartment #**
City	**Province**
Postal Code	**Which phone number to best reach you (i.e. Home)**
Home Phone	**Cell Phone**
Work Phone	**Email**

Family Physician

Do you currently have a family physician? (circle one) **Yes No**	**Name of last Family Physician**
Date you last saw your family physician	

Please circle the statement that best applies to you:

1. I have recently moved to Sarnia-Lambton and do not yet have a family physician
2. Until now, I have not needed a family physician
3. My previous family physician has either retired or moved.
4. My previous family physician is still practicing, but no longer provides me care.
5. I have a family physician but would like to switch to Dr. Peterson

If wishing to switch family physicians please provide detailed reason for this request

Current Health Concerns:
Brief Health History:

Declaration

As the practice is large, submission of an application form does not guarantee that you will be accepted as a patient of Dr. Peterson. If granted a first appointment, this appointment will be for a complete review of your medical history. You must bring all of your current medication bottles/inhalers/vials/patches to the appointment. You must have a valid Ontario Health Card. If at this first appointment either Dr. Peterson or you decide that the patient-physician relationship will be ineffective for any reason, either party may terminate the therapeutic relationship without further commitment. Previous prescriptions for opioid (narcotic) pain medication will not necessarily be continued with Dr. Peterson. Harassing or abusive behaviour towards Dr. Peterson or his staff will not be tolerated and will result in immediate cessation of the patient-physician relationship.

By signing, below, I acknowledge that I have read and understood the declarations and have answered all questions truthfully. If responses are found to be deceitful then the patient-physician relationship may be terminated.

_____ _____

Signature Date

****** Please return form to Dr. Peterson's office at**
481 London Road (second level), or
fax to 519-337-3257, or
scan and email to info@drpeterson.ca ***

For Office Use Only: Date Received:_____ Date Reviewed:_____