Queen Medical Centre
1591 Ouellette Ave. Unit 103
Windsor, Ontario N8X1K5
Tel (519) 419-4294 Fax: (519)419-1505

Patient Consent for Transfer/Registration as a Family Patient with Dr. Hussain

I, the undersigned, consent to the transfer/registration as a family patient with Dr. Hussain.

Patient Name: …….

Date of Birth: DD / MM / YYYY

Health Card Number (OHIP): ……

Version Code: …….

Full Address: …….

Phone (Home): ( ) -

Phone (Mobile): ( ) -

Email: …….

Preferred Contact Method: ☐ Phone ☐ Email ☐ Mail

Emergency Contact Name: ( ) -

Relationship: ……..…….

Emergency Contact Phone Number: ( ) -

Patient/Parent/Agent Signature: …….

Date: ___ / ___ / _____

Communication Consent

☐ I consent to receive appointment reminders, test results, and general communication by:

☐ Phone ☐ Email ☐ Text Message

Signature: _____

Date: ___ / ___ / _____

For Office Use Only:

Patient Registered By: …… Date: ……

Entered in EMR: ☐ Yes ☐ No Chart Number: ……