New Client Application Form

See page 2 for instructions

Belleville and Quinte West Community Health Centre

Applicant Information:

Last Name		**First Name**	
Preferred Name		**Date of Birth**	
Address			
City		**Postal Code**	
Email Address			
Home Phone		**Mobile Phone**	

Please note – It is your responsibility to inform the Centre if your contact information changes.

If you are completing this application on behalf of someone else – please complete the following:		
What is your name:	**Last Name:**	**First Name:**
What is your phone number:		
What is your relationship to the Applicant:		

Is it okay if we email you?	No ☐	Yes ☐
Is it okay if we leave a voicemail message for you?	No ☐	Yes ☐
Is it okay if we contact you about other BQWCHC services while you are on the waitlist?	No ☐	Yes ☐
Have you used the programs/services at the Centre in the past 5 years?	No ☐	Yes ☐
Preferred Location - Select only one	Quinte West ☐	Belleville ☐

Do you currently have a Primary Care Provider (Doctor or Nurse Practitioner)?	No ☐	Yes – Please explain below why you are looking for new Primary Care Provider

Do you have Health Insurance? (OHIP, Other Province Insurance, etc.)	No ☐	Yes ☐
Are you on a waitlist for Primary Care at any other organization?	No ☐	Yes ☐

BQWCHC prioritizes populations who face systemic barriers to health care. It helps us plan if we know the following, but answering is optional.

Check any that apply to you			
Indigenous	☐	Black or Person of Colour	☐
Immigrant/Refugee	☐	2SLGBTQI ☐ trans/transitioning/contemplative	☐
Living with a disability	☐	Living on a low-income	☐
Speak French as a First Language	☐	Do not speak French or English as a First Language	☐
Homeless/Under housed/Couch-surfing	☐	Living with Mental Health and/or Substance Use	☐

Social Support – Check any that apply to you			
If I need help, I can go to my family	☐	If I need help, I can go to my friends	☐
If I need help, I use the support of local services/programs	☐	If I need help, I don't know where to go	☐

Have you been to the Emergency Department in the last year?	No ☐	Yes – Please indicate how many times ->	

Are you Pregnant?	No ☐	Yes – Please provide expected due date (yy/mm/dd)>	YYYY-MM-DD

Do you have any chronic diseases, or is there anything you would like us to know about your health?	No ☐	Yes – Please explain below

Have you had a hard time receiving health services and supports because of problems with mental health or substance use?	No ☐	Yes – Please explain below

Instructions:

1. Please complete one form for each applicant

2. Complete this fillable form on computer and print OR Print form and complete manually (PLEASE PRINT)

3. Return by mail or in-person to:

Belleville and Quinte West Community Health Centre
161 Bridge St. W.
Belleville, ON
K8P 1K2
UNIT 1

OR

Belleville and Quinte West Community Health Centre
69 Catherine St.
Trenton, ON
K8V 5K9

For Office Use Only
Staff Involved: