St. Joseph's Healthcare Hamilton

**Specialist/Surgeon**.....

**Family Physician**.....

**Date of Admission/Treatment**.....

**Surgical** Day Surgery ☐ Overnight Admission ☐

**Maternity** ☐

**Medical** ☐

| Mr. ☐ Miss ☐ Mrs. ☐ | Patient Surname First Middle | |
|---|---|---|
| Home Address | | Apt. or Unit No. |
| City | Prov. / Postal | Home Phone ( ) / Business Phone ( ) |
| Date of Birth (year / month / day) | Age / Sex | Maiden or Alternate Name / Religion |
| Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ | | Name of Church |
| Employment Status: Not currently employed ☐ Self employed ☐ Full time ☐ Part time ☐ Retired ☐ | | |
| Patient's Employer | | **Employee Number** |
| Employer's Address | | **Patient's Social Insurance No.** |
| Previous Patient: Yes ☐ No ☐ | If yes, approximate date | |

**Please Note:** **You are required to use your legal name on health records. If you have been treated at St. Joseph's Healthcare Hamilton under a different name, please show this second name as an alternate name.**

## First Contact in Case of Emergency

| Name of Next of Kin. (Please list patient's closest relative, e.g. spouse, parent) | Relationship to Patient |
|---|---|
| Street Address / Apt. No. | Home Phone ( ) |
| City / Province / Postal Code | |

## Second Contact in Case of Emergency

| Name (Please complete if other than next of kin) | |
|---|---|
| Relationship to Patient | Phone Number ( ) |

## Provincial Health

| Provincial Insurance Number | Version Code / Expiry Date |
|---|---|
| Exact Name from Provincial Health Card | |

## WCB

Was condition or injury work related?

| If yes, complete last two lines | Claim No. | Date of Accident (year / month / day) | |
|---|---|---|---|
| Name of employer at time of accident | | | |