

New Client Application Form

See page 2 for instructions



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
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Is it okay if we leave a voicemail message for you?	No	Yes
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Is it okay if we contact you about other BQWCHC services while you are on the waitlist?	No	Yes
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Have you used the programs/services at the Centre in the past 5 years?	No	Yes
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Preferred Location - Select only one	Quinte West	Belleville
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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
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Are you on a waitlist for Primary Care at any other organization?	No	Yes
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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	<input type="checkbox"/>	If I need help, I can go to my friends	<input type="checkbox"/>
If I need help, I use the support of local services/programs	<input type="checkbox"/>	If I need help, I don't know where to go	<input type="checkbox"/>

Have you been to the Emergency Department in the last year?	No	Yes – Please indicate how many times ->	<input type="text"/>
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Are you Pregnant?	No	<input type="checkbox"/>	Yes – Please provide expected due date (yy/mm/dd)>	YYYY-MM-DD
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Do you have any chronic diseases, or is there anything you would like us to know about your health?	No	Yes – Please explain below
<input type="text"/>		

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
<input type="text"/>		

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: