

Surgery Date: _____

Please complete this form entirely and fax to Preoperative Assessment Clinic at the site where the surgery has been booked
7 business days prior to the Surgery Date. Please ensure all information is legible.
 GNG Fax: 905-358-4988 SCS Fax: 905-323-7564 WHS Fax: 905-735-8462

Patient Information:

Last Name: _____ First Name: _____

Date of Birth: _____ Male Have you used any form of tobacco in the last 6 months?
Month Day Year Female Yes No

Address: _____

City: _____ Postal Code: _____

Phone Number: _____ Alternate Number: _____

Marital Status: _____ Church / Religion: _____

Employer: _____

<p>1st Emergency Contact <input type="checkbox"/> Address is the same as above</p> <p>Name: _____</p> <p>Relationship to Patient: _____</p> <p>Address: _____</p> <p>City: _____ PC: _____</p> <p>Phone #: _____ Alt #: _____</p>	<p>2nd Emergency Contact:</p> <p>Name: _____</p> <p>Relationship to Patient: _____</p> <p>Address: _____</p> <p>City: _____ PC: _____</p> <p>Phone #: _____ Alt #: _____</p>
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<p>Surgeon: (Full First and Last Name)</p>	<p>Family Doctor: (Full First and Last Name)</p>	<p>Family Doctor to receive copies of reports? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Insurance Information:

Health Card Number: _____ Version Code: _____

Additional Health Insurance Company Name (i.e. Green Shield): _____

Policy / Group Number: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Employer: _____

If **WSIB**, Claim Number: _____ Social Insurance Number: _____

Name of Employer at Time of Injury: _____

Room Type Requested: Ward Semi-Private Private

Ontario Health Insurance covers **Ward Accommodation**.
 Patients should be aware that companies that provide supplementary insurance may not cover 100% of semi-private / private room charges.
Patients are responsible for knowing information related to their individual coverage.