SEAMO
Southeastern Ontario Academic Medical Organization

e±ŀăŀű

Primary Care Intake Form

First Name: ______________________ **Last Name:** ____________________

Profession: ____

CPSO # ______________________ **OHIP Billing #:** ____________________

ϜAccount type: ☐ Associated with organization ☐ Solo Account

Organization (if applicable): ____

Address: ____

City: ____

Phone (incl. extension): ______________________ **Postal Code:** ____________________

ONE ID Account: ____

Email: ____

Delegate Name (if applicable):

Delegate email (if applicable):

*Solo accounts are tied to the individual, and can be used with different organizations. Accounts associated with an organization can only be used with that organization.

Once complete, please forward to:

The SEAMO Digital Health Team

seamo.digitalhealth@queensu.ca

Disclaimer: By providing this information you confirm that {9! a h may collect, use and disclose űKŀă ŀyŦ2ŴYŀ·űŀ2yŕŀyŕ2ŴŘŜŴ ű2 follow-up with you and/or support you with signing up for Ŝ±ŀăŀűă. This may ŀyŎŧdzŘŜ ŘŀăŎŧ2ăŀyƎ űKŀă information to other relevant parties in order to provide you with the requested services.