

INITIAL INTAKE FORM

PLEASE PRINT

Date _____
(mm/dd/yyyy)

Have you ever been a patient here before? ☐ Yes ☐ No If Yes, when? _____
How did you learn about us? (if referred, please name the referral) _____

Patient Information (please complete all of the fields below)

Last Name		First Name		Intl.
Street Address			Home Tel.	
City/Town	Province	Postal Code	Work Tel.	
Date of Birth (mm/dd/yyyy)	Gender ☐ M ☐ F	SIN	Mobile	
Name of Emergency Contact	Relationship		Emergency Contact Tel.	
Name of Family Doctor	Family Doctor Tel.		Patient's Email	

Case Information (please indicate the reason for your visit and complete all of the related information)

☐ Automobile Accident	Date of Accident _____	Name of Automobile Insurance Company _____
Have you already reported your injuries to the insurance company?		☐ No ☐ Yes
Were you employed at the time of the accident?		☐ No ☐ Yes
Do you have a legal representative?		
☐ No ☐ Yes (please provide name) _____		
Do you have Extended Health Care benefits coverage?		
☐ No ☐ Yes (please provide name of insurer) _____		
☐ Work Injury	Date of Accident _____	Claim Number (if known) _____
Nurse Case Manager:		Tel. _____
WSIB Adjudicator:		Tel. _____
Do you require treatment as a result of work related injury?		☐ Yes ☐ No
☐ Other	Date of Accident _____	Claim Number (if known) _____

Patient Signature (please print your name, sign, and date)

To the best of my knowledge, I certify that the information provided above is true and correct.

Name of Patient	Signature of Patient	Date
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Please present the following documents:

- | | | | |
|--|---|--|--|
| ☐ Driver's License | ☐ Health Card (OHIP) | ☐ Police Report | ☐ Insurance Pink Slip |
| ☐ Extended Health Benefits Card | ☐ Other _____ | | |

Please note that 24-hour appointment cancellation notice is required to avoid charges.

Patient _____

FOR OFFICE USE ONLY

Motor Vehicle Accident

Policy No.		Claim No.	
Name of Insurance Company			
Street Address			
City/Town		Province	Postal Code
Adjuster Last Name		Adjuster First Name	
Adjuster Telephone No.		Adjuster Fax	
☐ Policy Holder Same as Patient	Last Name (Policy Holder)		First Name (Policy Holder)

Extended Health Coverage (Primary)

ID/Certificate No.	Policy/Group No.
Name of Insurance Company	
☐ Policy Holder Same as Patient	Date of Birth (Policy Holder) (mm/dd/yyyy)
Last Name (Policy Holder)	First Name (Policy Holder)

Schedule of Benefits

Service Type/Product Description	Max Coverage	Coverage per Visit
Physiotherapy		
Massage		
Orthotics		
Acupuncture		
Chiropractic		

Extended Health Coverage (Secondary)

ID/Certificate No.	Policy/Group No.
Name of Insurance Company	Date of Birth (Policy Holder)
Last Name (Policy Holder)	First Name (Policy Holder) (mm/dd/yyyy)

Schedule of Benefits

Service Type/Product Description	Max Coverage	Coverage per Visit
Physiotherapy		
Massage		
Orthotics		
Acupuncture		
Chiropractic		

Other

Slip & Fall Claim No.	Slip & Fall File No.
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