INITIAL INTAKE FORM

How did you learn about us?(if referred, please name the referral)_____

Patient Information(please complete all of the fields below)

LastName	First Name		Intl.
Street Address			HomeTel.
City/Town	Province	PostalCode	WorkTel.
DateofBirth(mm/dd/yyyy)	Gender ☐ M ☐ F		Mobile
Name of Emergency Contact	Relationship		Emergency Contact Tel.
			Patient's Email

Please upload the following documents:

Driver's License

Extended Health Benefits Card _____

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

☐ AutomobileAccident Date of Accident Name of Automobile Insurance Company _____

If Yes, please answer the questions:

Have you already reported your injuries to the insurance company? No Yes

Were you employed at the time of the accident? No Yes

Claim Number:_____

Policy Number:_____

Do you have Extended Health Carebenefits coverage?

Name of Adjustor:_____ ☐ NoYes(pleaseprovidenameofinsurer) _____

Adjustor's Contact:

☐ WorkInjury If yes ,Please answer the below questions _____

Date of Accident:

WSIB Claim Number:

☐

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

NameofPatient(First and Last Name)		Date