

PATIENT INFORMATION Please complete ALL fields below
Name:
Date of Birth: dd/mm/yyyy
Home Phone #:
Work Phone #:
Home Address: Street City Postal code
Email Address: Would you like appointment notifications by email? <input type="checkbox"/> Yes <input type="checkbox"/> No *Your email is never shared or rented.
Health Card #:
Emerg. Contact Name:
Relationship:
Emerg. Contact Phone #:
Previously attended our clinic? Yes/No Year: 20__

REFERRAL INFORMATION Please complete ALL fields below
How did you hear about our clinic?
Family Physician:
Referring Physician:
Did you stay in the hospital overnight for your injury? Yes or No (please circle)
Which Hospital?

WORKPLACE INJURY (WSIB) If this is a work related injury, please complete ALL fields below
Date of Injury:
Claim #:
Name of Employer:
Employer Contact Address & Phone #:

MOTOR VEHICLE ACCIDENT If this is an injury due to a motor vehicle accident, please complete ALL fields below
Date of Accident:
Insurance Company:
Adjuster's Name:
Adjuster's Phone #:
Adjuster's Fax #:
Adjuster's Address:
Policy / Claim #:
Previous received treatment for injuries sustained: Yes / No
Completed Accident Benefits Package (OCF 1)? Yes / No

EXTENDED HEALTH INSURANCE For us to bill on your behalf, please complete ALL fields below
Primary Insurance Company:
Plan /Group /Policy/Contract#:
ID/Certificate/Perm #:
Name of Policy Holder:
Date of Birth of Policy Holder:
Name of Employer:
Secondary Insurance Company:
Plan/Group/Policy/Contract#:
ID/Certificate/Perm#:
Name of Policy Holder:
Date of Birth of Policy Holder:
Name of Employer: