Intake Form

Name: ______________________________ DOB (m/d/y) __________________________
Address: ______________________________ Email: ______________________________
______________________________ Tel (H) ______________________________
City: __________________Prov: __________ Tel (C) ______________________________
Postal Code: ______________________________ Alternate contact name: __________________
Family Dr.: ______________________________ Alternate contact Tel: __________________
Family Dr. Address: _________________________ Emergency contact name: __________________
Family Dr. Tel: ______________________________ Emergency contact Tel: __________________

How did you find out about our clinic? ____

Do you have any specific needs such as female/male therapist, language needs, or a private room?

____

First Insurance Company

Insurance Co: _____________ Policy #: _______________ ID #:____________________
Policy Holder: _____________ Relationship: ____________ Pol. Holder DOB (m/d/y): ________
Physio: Max/yr: _____________@_________% Limit per visit: _________ Dr. referral: Y/N
Orthotics: max/yr: __________ @__________ % Dr. referral: Y/N

Second Insurance Company

Insurance Co: _____________ Policy #: _______________ ID #:____________________
Policy Holder: _____________ Relationship: ____________ Pol. Holder DOB (m/d/y): ________
Physio: Max/yr: _____________@_________% Limit per visit: _________ Dr. referral: Y/N
Orthotics: max/yr: __________ @__________ % Dr. referral: Y/N

M.V.A.

Insurance Co: ___________________________ Adjuster: ______________________________
Address: ______________________________ Claim #: ______________________________
City: ______________________________ Tel: _______________ Fax: _______________
Prov: ___________Postal code: ____________ Date of accident(m/d/y): __________________

WSIB

Date of Accident (m/d/y): ___________________ Claim #: ______________________________
Employer: ______________________________ S.I.N.: ______________________________
Address: ______________________________ Case manager: __________________________
City: ______________________________ Tel: ______________ Fax: _________________
Prov: __________Postal code: ______________ Nurse consultant: ________________________
Tel: ______________ Fax: _________________ Tel: _______________ Fax: _________________