CanadaPhysio Clinic #: _____
Address:
____

File #:___________________________
Patient Initial Visit: ___________________________

In order to serve you better, please take a moment to complete this form. If you require assistance, please see the receptionist. When finished, kindly return this form to the front desk.

Have you ever been a patient here before?	☐No	☐Yes	If Yes, when? ________________ (Month Day, Year (e.g. Jan. 1, 20xx)
How did you learn about us?	(If referred, please name the referral): ________________________		

Please present the following documents:

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

Patient Information: (Please complete all of the fields below)

Last Name:	First Name:	Middle Name:	☐ Male ☐ Female
Street Address:	Apt. #:	Home Tel.: ( )	
City/Town:	Prov.:	Postal Code:	Work Tel.: ( ) Ext. #:
Subscribe to E-mail Notification: ☐ Yes ☐ No			Mobile Tel.: ( )
E-mail address: ____			Preferred Contact: ☐ Home ☐ Work ☐ Mobile
Date of Birth: Month Day Year	Age:	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow ☐Widower ☐Common Law	
OHIP Health Card #:	Expiry Date: Month Day Year	Version:	Social Insurance Number: - -
Name of Emergency Contact:	Relationship:		Emergency Tel. #:
Name of Family Doctor:	Family Doctor Tel.:		Family Doctor Fax:

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

☐ Motor Vehicle Accident	Date of Accident:: ______________________ (Month / Day / Year – e.g. Jan. 1, 20xx) Name of Insurance Company: ______________________________ Have you reported your bodily injuries to the Insurance Company? (i.e. neck, low back) ☐Yes ☐No Do you have Extended Health Care benefits coverage? ☐Yes ☐No Do you have a legal representative? ☐Yes ☐No If Yes, __________________
☐ Work Injury (WSIB)	Date of Accident: ________________ (Month Day, Year (e.g. Jan. 1, 20xx) Name of Employer: ____________________ Employer Contact #: ____________________ Name of Lawyer: ____________________
☐ Slip & Fall	Date of Accident: ________________ (Month Day, Year (e.g. Jan. 1, 20xx) Name of Lawyer: ____________________ Lawyer Contact #: ____________________
☐ Extended Health/Private	Date symptoms appeared: ________________ (Month Day, Year (e.g. Jan. 1, 20xx)

Patient Signature: (I certify that the information provided above is true and correct)

Print Name:	Signature of Patient:	Date:______________ (Month Day, Year (e.g. Jan. 1, 20xx)
For Office Use Only: Intake Coordinator:	Signature of Intake Coordinator:	Date:______________ (Month Day, Year (e.g. Jan. 1, 20xx)