PATIENT INTAKE INFORMATION

Patient Information		
Last Name:	First Name & Middle Name:	Gender:
		☐ Male ☐ Female
Phone (Work):	Phone (Home/Cell):	Email:
Address:	City:	Postal Code:
Birthdate (mm/dd/yyyy):	Personal HealthCard #:	Emergency contact and phone #:
		Relationship:
Date of Injury (mm/dd/yyyy):	Claim Type:	Employer and Occupation:
	☐ WCB ☐ MVA ☐ Personal	
Medical Team		
Family Physician:	Referring Physician:	Specialist(s):

How did you find our clinic?

☐ Yellow Pages ☐ Signage ☐ Existing patient ☐ Friend / Family ☐ Internet ☐ Family Physician
☐ Referring Physician ☐ WCB/Insurance ☐ Newspaper/Magazine ☐ Other:________________

Fill out only if WCB or MVA			
Claim Number:	Adjuster Name:	Adjuster Phone #:	Adjuster Fax #:

Fill out only if DVA

Veteran Affairs #: _________________

Extended health insurance. ** Bring your policy number and our office staff will check your coverage
Ins. Company ______________ Policy # _________________ Employee ID # ________________

Physiotherapy coverage:	Massage Therapy coverage:	Chiropractic coverage:
Yearly max: ___________ ☐ Doctor's note required? Details:	Yearly max: ___________ ☐ Doctor's note required? Details:	Yearly max: ___________ ☐ Physio note required? ☐ Doctor's note required? Details:

OFFICE SECTION ONLY			
Assessment date	Description (Ie MVA – Shoulder)	Primary provider	Billing office
			Belmead
WCB/MVA diagnosis cd	WCB body part#	WCB injury #	End date

The following must be complete for all new patients:
☐ Patient has adequate coverage for therapy ☐ All fields on all new patient forms are complete
☐ All fields on this form are entered on computer program