

INITIAL INTAKE FORM

PLEASE PRINT

Date _____
(mm/dd/yyyy)



403 Parliament Street
Toronto, ON M5A 3A1
Phone: (416) 274-7979
Email: info@parliamentphysio.ca

Welcome to Parliament Physio Clinic! 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____
How did you learn about us? (if referred, please name the referral) _____

Patient Information (please complete all of the fields below)			
Last Name	First Name	Intl.	
Street Address			Home Tel.
City/Town	Province	Postal Code	Work Tel.
Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SIN	Mobile
Name of Emergency Contact	Relationship		Emergency Contact Tel.
Name of Family Doctor	Family Doctor Tel.	Patient's Email	

Case Information (please indicate the reason for your visit and complete all of the related information)	
<input type="checkbox"/> Automobile Accident	Date of Accident _____ Name of Automobile Insurance Company _____
	Have you already reported your injuries to the insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Were you employed at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Do you have a legal representative? <input type="checkbox"/> No <input type="checkbox"/> Yes (please provide name) _____
	Do you have Extended Health Care benefits coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes (please provide name of insurer) _____
<input type="checkbox"/> Work Injury	Date of Accident _____ Claim Number (if known) _____
	Nurse Case Manager: _____ Tel. _____
	WSIB Adjudicator: _____ Tel. _____
	Do you require treatment as a result of work related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other	_____

Patient Signature (please print your name, sign, and date)		
To the best of my knowledge, I certify that the information provided above is true and correct.		
Name of Patient	Signature of Patient	Date

Please present the following documents:			
<input type="checkbox"/> Driver's License	<input type="checkbox"/> Health Card (OHIP)	<input type="checkbox"/> Police Report	<input type="checkbox"/> Insurance Pink Slip
<input type="checkbox"/> Extended Health Benefits Card	<input type="checkbox"/> Other _____		

Please note that 24-hour appointment cancellation notice is required to avoid charges.

Patient _____

FOR OFFICE USE ONLY

Motor Vehicle Accident

Policy No.		Claim No.	
Name of Insurance Company			
Street Address			
City/Town		Province	Postal Code
Adjuster Last Name		Adjuster First Name	
Adjuster Telephone No.		Adjuster Fax	
<input type="checkbox"/> Policy Holder Same as Patient	Last Name (Policy Holder)	First Name (Policy Holder)	

Extended Health Coverage (Primary)

ID/Certificate No.		Policy/Group No.	
Name of Insurance Company			
<input type="checkbox"/> Policy Holder Same as Patient	Date of Birth (Policy Holder) (mm/dd/yyyy)		
Last Name (Policy Holder)		First Name (Policy Holder)	

Schedule of Benefits

Service Type/Product Description	Max Coverage	Coverage per Visit
Physiotherapy		
Massage		
Orthotics		
Acupuncture		
Chiropractic		

Extended Health Coverage (Secondary)

ID/Certificate No.		Policy/Group No.	
Name of Insurance Company		Date of Birth (Policy Holder)	
Last Name (Policy Holder)		First Name (Policy Holder) (mm/dd/yyyy)	

Schedule of Benefits

Service Type/Product Description	Max Coverage	Coverage per Visit
Physiotherapy		
Massage		
Orthotics		
Acupuncture		
Chiropractic		

Other

Slip & Fall Claim No.	Slip & Fall File No.