

Date

 Welcome to **Whitby Physiotherapy & Wellness!** 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? ^{Yes} 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	Gender	<input type="checkbox"/> M <input type="checkbox"/> F	Mobile	
Email				
Name of Emergency Contact		Relationship		Emergency Contact Tel.
Name of Family Doctor			Family Doctor Tel.	

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 No. (if known)	File No. (if known)	
	First/Last Name		Tel/Fax	
<input type="checkbox"/> Slip & Fall	Date of Accident	Claim No. (if known)	File No. (if known)	
<input type="checkbox"/> Sports Injury	Date of Accident	Claim No. (if known)		
<input type="checkbox"/> Other				

Patient Signature (please print your name, date and sign)

To the best of my knowledge, I certify that the information provided above is true and correct.

Name of Patient	Signature	Date
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Please present the following documents:
 Driver's License Health Card Police Report Insurance Pink Slip Extended Health Other

FOR OFFICE USE ONLY**Motor Vehicle Accident**

Policy No.	Claim No.
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Name of Insurance Company

Street Address

City/ Town	Province	Postal Code
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Adjuster Last Name	Adjuster First Name
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Adjuster Telephone No.	Adjuster Ext.	Adjuster Fax No.
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<input type="checkbox"/> Policy Holder Same as Patient	Last Name (Policy Holder)	First Name (Policy Holder)
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Extended Health Coverage (Primary)

ID/ Certificate No.	Policy/ Group No.
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Name of Insurance Company

Street Address

City/ Town	Province	Postal Code
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<input type="checkbox"/> Policy Holder Same as Patient	Last Name (Policy Holder)	First Name (Policy Holder)
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Schedule of Benefits

Service Type/ Product Description	Max Coverage	Coverage per Visit
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Extended Health Coverage (Secondary)

ID/ Certificate No.	Policy/ Group No.
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Name of Insurance Company

Street Address

City/ Town	Province	Postal Code
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Last Name (Policy Holder)	First Name (Policy Holder)
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Schedule of Benefits

Service Type/ Product Description	Max Coverage	Coverage per Visit
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