INITIAL INTAKE FORM

PLEASE PRINT

Date

Welcome to CENTRO PHYSIO ! 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 ☐ M ☐ 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)

☐ Automobile Accident — Date of Accident — Name of Automobile Insurance Company

Have you already reported your injuries to the insurance company? ☐ No ☐ Yes

Were you employed at the time of the accident? ☐ No ☐ Yes

Do you have a legal representative?
☐ No ☐ Yes (please provide name)

Do you have Extended Health Care benefits coverage?
☐ No ☐ Yes (please provide name of insurer)

☐ Work Injury — Date of Accident — Claim No. (if known) — File No. (if known)
First/Last Name — Tel/Fax

☐ Slip & Fall — Date of Accident — Claim No. (if known) — File No. (if known)

☐ Sports Injury — Date of Accident — Claim No. (if known)

☐ 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

Please present the following documents:

☐ Driver's License ☐ Health Card ☐ Police Report ☐ Insurance Pink Slip ☐ Extended Health ☐ Other

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 Ext.	Adjuster Fax No.
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	
Street Address	
City/ Town	Province / Postal Code
Policy Holder Same as Patient	Last Name (Policy Holder) / First Name (Policy Holder)

Schedule of Benefits

Service Type/ Product Description	Max Coverage	Coverage per Visit

Extended Health Coverage (Secondary)

ID/ Certificate No.	Policy/ Group No.
Name of Insurance Company	
Street Address	
City/ Town	Province / Postal Code
Last Name (Policy Holder)	First Name (Policy Holder)

Schedule of Benefits

Service Type/ Product Description	Max Coverage	Coverage per Visit