

Date

Welcome to **Claireville Physiotherapy and Rehab Centre** ! 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
-----------------	-----------	------

**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