



# INITIAL INTAKE FORM

PLEASE PRINT

Date \_\_\_\_\_  
(mm/dd/yyyy)

Welcome to New Hope Physiotherapy & 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 (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)

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 Number (if known) \_\_\_\_\_

Nurse Case Manager: \_\_\_\_\_ Tel. \_\_\_\_\_

WSIB Adjudicator: \_\_\_\_\_ Tel. \_\_\_\_\_

Do you require treatment as a result of work related injury?       Yes  No

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
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**Please present the following documents:**

Driver's License       Health Card (OHIP)       Police Report       Insurance Pink Slip

Extended Health Benefits Card       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.	
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