**PATIENT INFORMATION Client Number:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: | | |  | | | | | | | | | | First Name: | | | | |  | | |
| Address: | |  | | | | | | | | | | | | | | | | | | |
| Apt: |  | | | City: | | |  | | | | Prov: | | |  | | | Postal Code: | | |  |
| Home Phone: | | | | ( ) | | | | | | | | | Cell Phone: | | | | | ( ) | | |
| Date of Birth: | | | | DD | |  | | MM |  | YYYY | | |  | | | Marital Status: | | |  | |
| Email: | |  | | | | | | | | | | | | | | | | | | |
| Initial Intake Date: | | | | | DD | | |  | MM |  | | YYYY | | |  |
| **How did you hear about the clinic?** | | | | | | | | | |  | | | | | | | | | | |

**FAMILY DOCTOR INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Doctor Name: |  | | | |
| Phone: | | ( ) | Fax: | ( ) |

**PRIVATE HEALTH NSURANCE**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| EHB Company Name: | | |  | | | | | | |
| Name of Insured: | |  | | | | | | | | |
| Group#: |  | | | ID#: |  | | Certificate: | |  | |
| Coverage: |  | | | Max Chiro $ |  | | Max Massage $ | |  | |
| Occupation: |  | | |  | |  | |  | | |

I hereby declare that all the information given above is accurate and current to the best of my knowledge. If any information changes I will contact immediately.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**CONSENT TO RELEASE INFORMATION**

I, *(please print name)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby authorize and/or its employees to obtain and review copies of all medical, hospital, clinical, practitioner’s notes / reports, employment, vocational, insurance and legal documents including the full and final settlement documents or any other related records or documents, and share or discuss pertinent information with appropriate qualified medical and paramedical professionals or others involved in my treatment, rehabilitation, claims or representation. This release is valid for two years from the date signed unless otherwise directed by myself. I agree that a photocopy of this release form is valid.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: | |  | | | | | | | | |
|  | *please print* | | | | | | | | | |
| Address: |  | | | | | | | | | |
|  |  | | | | | | | | | |
|  |  | | | | | | | | | |
|  | | |  |  | | | | |  | |
| Dated in Toronto, Ontario this | | | | | |  | day of |  | | month, 2018 |
|  | | | | | | | | | | |
| Patient Signature | | | | |  | | | | | |
|  | | | | |  | |  | | | |
| Authorized Signature for Patient | | | | |  | | Witness Signature | | | |
|  | | | | |  | |  | | | |
| Name of Authorizing Signature *(please print)* | | | | | | | Witness Name *(please print)* | | | |