



2520 Eglinton Avenue West, Unit 5-6 Mississauga, ON L5M 0Y4
Tel: 905 997-0113/ 905 997 0212 Fax: 905 997-0214

Name (Last) _____ (First) _____
Date of Birth (mm _____ dd _____ yyyy _____) Age _____ F M
Address _____
City _____ Postal Code _____
Phone # (home) _____ (cell#) _____ (work)# _____
Email: _____ Would you like to be notified by email? Yes No
Emergency Contact Name: _____ Phone# _____

Who has referred you to our clinic? _____
(physician, friend, family, yellow pages, internet/website, location, other)

Family Physician

Name _____ Phone # _____

Employment Information

Company Name _____ Occupation _____
Immediate Supervisor name: _____ Phone # _____

EXTENDED HEALTH CARE INFORMATION

1st Insurance Company Name _____
Policy # _____ ID/Cert # _____
Policy holder name _____ Date of Birth _____

2nd Insurance Company Name _____
Policy # _____ Id # _____
Policy Holder Name _____ Date of Birth _____

I am covered under only one insurance policy _____ *Signature* _____
I am covered under a secondary insurance policy _____ *Signature* _____

AUTO INSURANCE INFORMATION (Motor Vehicle Accident Patient ONLY)

Insurance Company Name _____
Date of Accident _____ Policy # _____ Claim # _____
Adjuster's Name _____ Phone# _____ Fax # _____

WSIB INFORMATION (Work Injuries Patient ONLY)

Claim # _____ Date of injury _____ SIN # _____
Health Card # _____ Adjuster name _____ Phone # _____
Nurse Case Manager _____ Phone # _____ Fax# _____

Lawyer/Legal Representative (if applicable)

Name: _____ Phone # _____ Fax# _____