# PATIENT INFORMATION SHEET

Male: ☐ Female: ☐ Date: _____

| **Last Name:** | | **First Name:** | |
|---|---|---|---|
| Address: | | | Apt. #: |
| City: | Prov: ON | Postal Code: | D.O.B.: DD MM YY |
| Home Number: | | Cell Number: | |
| Health Card No.: | VC: | Work Number: | |

| **WSIB** | |
|---|---|
| Claim No.: | Date of Loss: DD MM YY |
| Adjudicator Last Name: | First Name: |
| Phone Number: ext.: | Fax Number: |
| Nurse Case Manager Last Name: | First Name: |
| Phone Number: | Extension: |

| **Employment Information:** | | | | | |
|---|---|---|---|---|---|
| Phone No.: | | | | | Occupation: |
| **EHC Insurance:** | | | | | Phone No.: |
| Chiro. Coverage: Max:$ | %: | Ref: Y ☐ N ☐ | Init:$ | Sub:$ | Policy/Group No.: |
| Physio Coverage: Max:$ | %: | Ref: Y ☐ N ☐ | Init:$ | Sub:$ | |
| RMT Coverage: Max:$ | %: | Ref: Y ☐ N ☐ | Init:$ | Sub:$ | ID/Certificate No.: |
| ACU Coverage: Max:$ | %: | Ref: Y ☐ N ☐ | Init:$ | Sub:$ | Calendar Year: |
| Orthotic Insoles: Max:$ | %: | Ref: Y ☐ N ☐ | Init:$ | Sub:$ | Insurance Assignment: Y ☐ N ☐ |
| Orthotic Shoes: Max:$ | %: | Ref: Y ☐ N ☐ | Init:$ | Sub:$ | |
| Compression Stockings: Max: $ | %: | Ref: Y ☐ N ☐ | | | No. of Pairs: |
| Policy Holder: | | | | | DOB (if spouse): |

| **Family Physician:** | |
|---|---|
| Address: | |
| Phone No.: | Fax No.: |
| **Specialist:** | |
| Phone No.: | Fax No.: |

| **Law Firm Information** | |
|---|---|
| Name of Lawyer/Representative: | |
| Address: | |
| Phone No.: | Fax No.: |

| **Did You Attend Another Facility: Yes: ☐ No: ☐** | **Last Date Attended: DD MM YY** |
|---|---|
| Name of Facility: | Phone No.: |