Bramalea Physiotherapy & Wellness

INITIAL INTAKE FORM
PLEASE PRINT

Date

Welcome to Bramalea Physiotherapy! 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 ☐ M ☐ 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)

☐ 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 No. (if known) | File No. (if known)
First/Last Name | Tel/Fax

☐ Slip & Fall
Date of Accident | Claim No. (if known) | File No. (if known)

☐ Sports Injury
Date of Accident | Claim No. (if known)

☐ 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