

**Date**

Welcome to WestBram Physiotherapy & Wellness ! 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?  <sup>Yes</sup>  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	<input type="checkbox"/> M <input type="checkbox"/> 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
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**Please present the following documents:**

Driver's License  Health Card  Police Report  Insurance Pink Slip  Extended Health  Other

**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)
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**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)
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Schedule of Benefits

Service Type/ Product Description	Max Coverage	Coverage per Visit
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**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
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