2520 Eglinton Avenue West, Unit 5-6, Mississauga, L5M 0Y4
Tel: 905-997-0113 | 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# _____