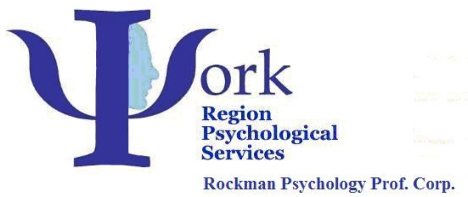

CONFIDENTIAL PATIENT INFORMATION

Please complete this form. **PLEASE PRINT OR WRITE LEGIBLY**.

NAME: Ms./ Mrs./ Mr.

____

(last) (first) (middle)

Email: ____

Address: ____

_______________________________ Postal code: ________________

Phone Number: (Home) (_ _ _) _ _ _ - _ _ _ _ Msg: ❑ Yes ❑ No

(Other) (_ _ _) _ _ _ - _ _ _ _ Msg: ❑ Yes ❑ No

Age: ________ Date of Birth: (mm/dd/yy) _ _ /_ _ /_ _

ID: ______________ _______________________________

(type of ID) (ID No.)

Marital Status: (please circle one) Single/Married/Separated/Divorced/Widowed/Other

Education: (Highest grade) _____ Occupation: ______________________________

Referred by: ______________________________

EXTENDED HEALTH PLAN

COMPANY NAME:____________________________POLICY NO.__________________

WSIB Claim No: _____________________________

WSIB Case manager: __________________________________

LEGAL REPRESENTATIVE:

Name: _________________________________ Phone number: (_ _ _) _ _ _ - _ _ _ _

FAMILY PHYSICIAN:

Name: _________________________________ Phone number: (_ _ _) _ _ _ - _ _ _ _

EMERGENCY CONTACT PERSON:

Name: _______________________________Relationship to Client: __________________

Phone #: (Home) (_ _ _)_ _ _-_ _ _ _ (Work) (_ _ _)_ _ _-_ _ _ _

Signature: ______________________________________ Date: __________________

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