

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: _____