

T

Driver's

License

Health Card

Police

Report

## INITIAL INTAKE FORM PLEASE PRINT

Date

	ome to Sandalwood Physiotherapy & Wellness! In order to serve you better , please take a moment to complete this form. If you re assistance, please see the receptionist. When Finished, kindly return this form to the front desk.								
Have you ever been a patient here before?		¬ No	If Yes, when?						

• — — — — — — — — — — — — — — — — — — —							
How did you learn about us? (if referred, please name the referral)							
Patient Information	on (please complete	all of the fields b	elow)				
ast Name			First Name			Intl.	
reet Address					Home Tel.	'	
ty/ Town		Province	Postal Code		Work Tel.		
ate of Birth		Gender	□М	□F	Mobile		
mail							
ame of Emergency Con	ntact	Relationship			Emergency Contac	t Tel.	
ame of Family Doctor					Family Doctor Tel.		
Case Information	(please indicate th	ne reason for voi	ır visit and	complete all of the	elated informati	on)	
Case Information (please indicate the reason for your visit and complete all of the related information)   □ Automobile Accident Name of Automobile Insurance Company							
	Have you alrea	ady reported you	ır injuries to	the insurance com	pany?		
Were you employed at the time of the egident?							
Do you have a legal representative?						) ⊔Yes	
□ No □ Yes (please provide name)							
Do you have Extended Health Care benefits coverage?							
☐ No ☐ Yes (please provide name of insurer)							
	Date of Accident	Claim N	lo. (if known)	F	ile No. (if known)		
☐ Work Injury	First/Last Name			Т	el/Fax		
☐ Slip & Fall	Date of Accident	Claim N	lo. (if known)	F	ile No. (if known)		
Sports Injury Date of Accident Claim No. (if known)							
☐ Other							
Patient Signature	(please print your	name, date and	sign)				
the best of my knowledge, I certify that the information provided above is true and correct.							
ame of Patient			Signature		Date		
Please present the following documents:							

Insurance

Pink Slip

Evtended Health

□Other

Service Type/ Product Description

## FOR OFFICE USE ONLY

Motor Vehicle Accident				
Policy No.		Claim No.		
Name of Insurance Company	anadalika walayo amaka keninga da managa kuma a kanaa ba yanin nga ana ana	a distribution in the second s		
Street Address				inn de sieder Annelse bie Miner (inn dem "die den "die "den Miner Annelsen", en «do des "die de
City/ Town	ericke der de mellete met een mit dem konty-mildele bellet okste der beste der met de bis behelving van de bis de	indicandida adareka, da ili ili ili ili ili andrea, anteriori del del como del cuid	Province	Postal Code
Adjuster Last Name		Adjuster First Nam	9	
Adjuster Telephone No.	Adjuster Ext.	Adjuster Fax No.	Camara a reference a mena come descendi fa medicable contribute de marte, a de mel medico, a m	arke land the methodors of a close obtained have record an analysis made of close for a land to a side or a land to
Policy Holder Same as Patient	Last Name (Policy Holder)		First Name (Policy Holde	r)
Extended Health Coverage	(Primary)			
ID/ Certificate No.		Policy/ Group No.		
Name of Insurance Company				
Street Address		da maradilika y Molda, yana kushada a Ministrika abamaka abistika a Asima Andrika		
City/ Town			Province	Postal Code
Policy Holder Same as Patient	Last Name (Policy Holder)		First Name (Policy Holde	r)
Schedule of Benefits	<u> </u>			
Service Type/ Product Description	n		Max Coverage	Coverage per Visit
Extended Health Coverage	(Secondary)			
D/ Certificate No.	(Secondary)	Policy/ Group No.		
D) Gertificate No.		ir olicyr Group 140.		
Name of Insurance Company	to Mariel and Aries Allina (Comp. Maries Aries Ann. Aries Ar			Make the Make And and and a Make and Make And Andread And Andread Andr
Street Address			Microstonellina a seria del mitalia del del del del collegio del colle	
City/ Town			Province	Postal Code
Last Name (Policy Holder)		First Name (Policy	Holder)	
Schedule of Benefits				

Max Coverage

Coverage per Visit