20 Polonia Avenue, Unit 106
Brampton, ON L6Y 0K9
Tel: (905) 452-7778
Fax: (905) 452-7779

INITIAL INTAKE FORM

PLEASE PRINT

Date 29-Oct-2015

Welcome to Millennium Physiotherapy Inc! 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? ☐ Yes ☐ 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	☐ M ☐ 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

Please present the following documents:

☐ Driver's License ☐ Health Card (OHIP) ☐ Police Report ☐ Insurance Pink Slip ☐ Extended Health Benefits Card ☐Other ______

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Patient ______________________________

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)	

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)	

Schedule of Benefits

Service Type/ Product Description	Max Coverage	Coverage per Visit

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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