POLYHEALTH
PHYSIOTHERAPHY REHAB INC.

INITIAL INTAKE FORM

Date: _____

In order to serve you better, please take a few minutes to complete this form.

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 ☐ Police Report ☐ Insurance Pink Slip ☐ Extended Health Plan ☐ Other

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