PATIENT INFORMATION FORM

Name: Last: ________________________________ First:________________________________ Middle:______________________________

Address: ____City:_________________________________ Province: ____________

Postal Code: _______________ E-mail address: ____
*E-Mail used for appointment reminders, receipts, clinic updates and birthday wishes. You may opt out at any time.

Cell Phone: ______________________ Home Phone: ___________________________ Work: _______________________________

Age: _______ Date of Birth: _______________________ Alberta Health#: ____

Gender:________________ *Refers to current gender which may be different than what is indicated on your insurance policies.

Sex:___________ *This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file.

Occupation: _________________________________ Employer: ____

Marital Status: _______________ Name of Spouse: ____

Family Medical Doctor: _________________________________ Location: ____

Emergency Contact: _____________________________________ Phone: ____

List your medications and the condition you take them for ____

____

How did you hear about our office? ____

Date of last spinal or hip x-ray: ______________________________ Where was it taken ?____

INJURY CLAIM ONLY: WCB? YES/NO **MOTOR VEHICLE ACCIDENT**? YES/NO

Date of injury: _________________________ Has your injury been reported? YES/NO

WOMEN ONLY: Are you pregnant? YES/ NO/ UNSURE # of weeks: ____

OB/Midwife/Doula: ____________________ Other: Practitioners: ____

Do you have extended health benefits? YES/ NO

Name of Policy Holder:_____________________________________ Policy Holder Date of Birth:_____________________________

Primary Insurance Company _____________________ Policy# ___________________________Member ID#:_________________________

Secondary Insurance Company ___________________ Policy# ___________________________Member ID#:_________________________

When doctors/therapists work together it benefits you. May we have your permission to update your health care practitioner(s) regarding your care at this office? YES/NO

LATE CANCELLATIONS AND NO SHOW POLICY:

ALL late cancellations and no-show appointments are subject to a 50% fee of the affected booking(s). We require a MINIMUM of 24-hours notice to cancel or change appointments. Initial: _______