PATIENT INFORMATION SHEET

Male: ☐ Female: ☐ Date: _____

Last Name:		**First Name:**	
Address:			Apt. #:
City:	Prov: ON	Postal Code:	D.O.B.: DD MM YY
Home Number:		Cell Number:	
Health Card No.:	VC:	Work Number:	

WSIB	
Claim No.:	Date of Loss: DD MM YY
Adjudicator Last Name:	First Name:
Phone Number: ext.:	Fax Number:
Nurse Case Manager Last Name:	First Name:
Phone Number:	Extension:

Employment Information:					
Phone No.:					Occupation:
EHC Insurance:					Phone No.:
Chiro. Coverage: Max:$	%:	Ref: Y ☐ N ☐	Init:$	Sub:$	Policy/Group No.:
Physio Coverage: Max:$	%:	Ref: Y ☐ N ☐	Init:$	Sub:$	
RMT Coverage: Max:$	%:	Ref: Y ☐ N ☐	Init:$	Sub:$	ID/Certificate No.:
ACU Coverage: Max:$	%:	Ref: Y ☐ N ☐	Init:$	Sub:$	Calendar Year:
Orthotic Insoles: Max:$	%:	Ref: Y ☐ N ☐	Init:$	Sub:$	Insurance Assignment: Y ☐ N ☐
Orthotic Shoes: Max:$	%:	Ref: Y ☐ N ☐	Init:$	Sub:$	
Compression Stockings: Max: $	%:	Ref: Y ☐ N ☐			No. of Pairs:
Policy Holder:					DOB (if spouse):

Family Physician:	
Address:	
Phone No.:	Fax No.:
Specialist:	
Phone No.:	Fax No.:

Law Firm Information	
Name of Lawyer/Representative:	
Address:	
Phone No.:	Fax No.:

Did You Attend Another Facility: Yes: ☐ No: ☐	**Last Date Attended: DD MM YY**
Name of Facility:	Phone No.: