

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 <input type="checkbox"/> N <input type="checkbox"/> Init:\$ Sub:\$	Policy/Group No.:
Physio Coverage: Max:\$ %:	Ref: Y <input type="checkbox"/> N <input type="checkbox"/> Init:\$ Sub:\$	
RMT Coverage: Max:\$ %:	Ref: Y <input type="checkbox"/> N <input type="checkbox"/> Init:\$ Sub:\$	ID/Certificate No.:
ACU Coverage: Max:\$ %:	Ref: Y <input type="checkbox"/> N <input type="checkbox"/> Init:\$ Sub:\$	Calendar Year:
Orthotic Insoles: Max:\$ %:	Ref: Y <input type="checkbox"/> N <input type="checkbox"/> Init:\$ Sub:\$	Insurance Assignment: Y <input type="checkbox"/> N <input type="checkbox"/>
Orthotic Shoes: Max:\$ %:	Ref: Y <input type="checkbox"/> N <input type="checkbox"/> Init:\$ Sub:\$	
Compression Stockings: Max: \$ %:	Ref: Y <input type="checkbox"/> N <input type="checkbox"/>	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: <input type="checkbox"/> No: <input type="checkbox"/>	Last Date Attended: DD MM YY
Name of Facility:	Phone No.: