SHERWOODPARK SportsPhysiotherapy

PATIENT REGISTRATION FORM

Name: _____ **Male** **Female**
First **Middle** **Surname**

Address: _____ **City:** _____ **Prov:** _____ **Postal Code:**_____

Primary Phone: (_____) _____ - _____ **Alternate Phone:** (_____) _____ - _____

Email address: _____

Date of Birth: _____/_____/_____ **Age:** _____ **Personal Healthcare No.**_____
Year **Month** **Day**

Emergency Contact: _____ **Phone:** (_____) _____ - _____

Family Physician: _____ **Phone:** (_____) _____ - _____

1. Have you been a patient of ours before? Y N
2. Have you received assessment or treatment for this body part at another physiotherapy clinic since April 1? Y N
3. Was this injury a fracture or have you had surgery in the last 8 weeks? Y N
4. Is this injury the result of a workplace accident (WCB)? Y N
5. Is this injury the result of a motor vehicle accident that has occurred in the past 90 days? Y N
6. Do you or your spouse have insurance benefits that cover physiotherapy? Name of company _____ Y N
7. Were you injured in a game or practice of an organized sport? Y N ❑ Soccer ❑ Hockey Other_____

HAVE YOU EVER OR ARE CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING

❑ Seizures/Stroke	❑ Bleeding problems	❑ Depression	Do you have a Pacemaker? ❑
❑ Osteoporosis	❑ Blood Clots	❑ Chest Pain/Angina	Are you Pregnant? ❑ ____ wks
❑ Cancer	❑ Anemia	❑ High Blood Pressure	

What part of your body is presently injured? _____ When were you injured? _____

Patient Advisement of Purpose of Collection of Health Information
Pleased be advised the registration information collected will be used for creating a patient file and billing purposes. The information is being collected under the authority of sections 20(b) and 21(1) of the Health Information Act. The Health Information Act provides for sharing of patient information between healthcare providers when said sharing contributes to the continuing care and treatment of the patient. _____ Initial

Acknowledgement/Consent
I understand my diagnosis and treatment plan will be discussed and that I have the right to question and/or refuse treatment prior to it being applied. I take responsibility to ensure I understand the nature of the services and understand that no guarantees have been make to me as to the results of services. This consent is effective until such time as I withdraw my consent in writing. _____ Initial

Missed Appointments – Cancelation Policy
In the event that you unable to keep your scheduled appointment, please contact us by phone at least 24 hrs prior to your appointment. Failure to attend an appointment or canceling on the day of your appointment is subject to a $30.00 no show/cancellation fee. **Note:** We recognize that there are certain circumstances that are out of your control (sudden illness, family emergency) and your therapist may make exception to the above policy in these limited cases.

Signature of Patient or Legal Guardian: _____ **Date:** _____

How did you hear about us?
❑ Website ❑ Physician _____ ❑ Insurance co. ❑ Friend/family ❑ Previous patient ❑ Other _____
Please check this box if you would be interested in receiving information regarding **Nutrition**. ❑

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