

## 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 include physiotherapy<br>If yes, name of company _____  | Y | N |
| 7. Were you injured in a game or practice of an organized sport? <input type="checkbox"/> Soccer <input type="checkbox"/> Hockey <input type="checkbox"/> Other _____ | Y | N |

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

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Seizures/Stroke | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Depression          | Do you have a Pacemaker? <input type="checkbox"/>   |
| <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Blood Clots       | <input type="checkbox"/> Chest Pain/Angina   | Are you Pregnant? <input type="checkbox"/> ____ wks |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Anemia            | <input type="checkbox"/> High Blood Pressure |   |

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

### Patient Advisement of Purpose of Collection of Health Information

Please 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 made 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 – Cancellation Policy

In the event that you are 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.

### How did you hear about us?

Website  Physician \_\_\_\_\_  Insurance co.  Friend/family  Social Media  Other \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_