CAREWELL PHYSIOTHERAPY & REHAB INC.
2677 Kennedy Rd., Unit # 2,Scarborough, ON M1T 3H8
Tel: 416 688 5850 Fax: 416 981 3314
Email: carewellclinics@gmail.com

INITIAL INTAKE FORM

PLEASE PRINT

Date _____
(mm/dd/yyyy)

Welcome to Carewell Physiotherapy & Rehab Inc.! In order to serve you better, please take a moment to complete this form. If you require assistance, please see the receptionist. When finished, kindly return this form to the front desk.

Have you ever been a patient here before? ☐ Yes ☐ No If Yes, when? _____

How did you learn about us? (if referred, please name the referral) _____

Patient Information (please complete all of the fields below)

Last Name	First Name		Intl.
Street Address			Home Tel.
City/Town	Province	Postal Code	Work Tel.
Date of Birth (mm/dd/yyyy)	Gender ☐ M ☐ F	SIN	Mobile
Name of Emergency Contact	Relationship		Emergency Contact Tel.
Name of Family Doctor	Family Doctor Tel.		Patient's Email

Case Information (please indicate the reason for your visit and complete all of the related information)

☐ Automobile Accident

Date of Accident _____ Name of Automobile Insurance Company _____

Have you already reported your injuries to the insurance company? ☐ No ☐ Yes

Were you employed at the time of the accident? ☐ No ☐ Yes

Do you have a legal representative?

☐ No ☐ Yes (please provide name) _____

Do you have Extended Health Care benefits coverage?

☐ No ☐ Yes (please provide name of insurer) _____

☐ Work Injury Date of Accident _____ Claim Number (if known) _____

Nurse Case Manager: Tel.

WSIB Adjudicator: Tel.

Do you require treatment as a result of work related injury? ☐ Yes ☐ No

☐ Other _____

Patient Signature (please print your name, sign, and date)

To the best of my knowledge, I certify that the information provided above is true and correct.

Name of Patient	Signature of Patient	Date

Please present the following documents:

☐ Driver's License ☐ Health Card (OHIP) ☐ Police Report ☐ Insurance Pink Slip

☐ Extended Health Benefits Card ☐ Other _____

Please note that 24-hour appointment cancellation notice is required to avoid charges.

Patient _____

FOR OFFICE USE ONLY

Motor Vehicle Accident

Policy No.	Claim No.
Name of Insurance Company	
Street Address	
City/Town / Province / Postal Code	
Adjuster Last Name	Adjuster First Name
Adjuster Telephone No.	Adjuster Fax
☐ Policy Holder Same as Patient	Last Name (Policy Holder) / First Name (Policy Holder)

Extended Health Coverage (Primary)

ID/Certificate No.	Policy/Group No.
Name of Insurance Company	
☐ Policy Holder Same as Patient	Date of Birth (Policy Holder) (mm/dd/yyyy)
Last Name (Policy Holder)	First Name (Policy Holder)

Schedule of Benefits

Service Type/Product Description	Max Coverage	Coverage per Visit
Physiotherapy		
Massage		
Orthotics		
Acupuncture		
Chiropractic		

Extended Health Coverage (Secondary)

ID/Certificate No.	Policy/Group No.
Name of Insurance Company	Date of Birth (Policy Holder)
Last Name (Policy Holder)	First Name (Policy Holder) (mm/dd/yyyy)

Schedule of Benefits

Service Type/Product Description	Max Coverage	Coverage per Visit
Physiotherapy		
Massage		
Orthotics		
Acupuncture		
Chiropractic		

Other

Slip & Fall Claim No.	Slip & Fall File No.