



CAREWELL PHYSIOTHERAPY & REHAB INC.

2677 Kennedy Rd., Unit # 2, Scarborough, ON M1T 3H8
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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 <input type="checkbox"/> M <input type="checkbox"/> 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
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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	
<input type="checkbox"/> 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			
<input type="checkbox"/> 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.	
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