WELCOME TO OUR PRACTICE

Name: _____
(First) (Middle) (Last)

Sex: Male ☐ Female ☐ Date of birth _____ /_____ /_____
MM DD YYYY

Address: _____City: _____ Province: _____
Postal Code: _____

Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Email: _____ Health Care Number: _____

Medical Doctor: _____ Phone: (_____)_____

Responsible for Account: Self Parent/Guardian _____ Other _____

If under age, parent/guardian name: _____ Phone: (_____)_____

Address (if different than above): _____

Emergency contact: Name: _____ Phone: (_____)_____

Referred by: _____

Insurance Information:

Primary Insurance Company

Policy Holder Name: _____ Relationship to Patient: _____
Date of birth _____/_____/_____

Address (if different than above): _____

Insurance Company Name: _____

Group/Policy Number: _____ ID/Certificate Number: _____

Employer: _____

Secondary Insurance Company

Policy Holder Name: _____ Relationship to Patient: _____
Date of birth _____/_____/_____

Address (if different than above): _____

Insurance Company Name: _____

Group/Policy Number: _____ ID/Certificate Number: _____

Employer: _____