Wellington Physiotherapy

1. **PERSONAL INFORMATION**

Name:_____ Date of Birth:_____(mm/dd/yy)
Address:_____
City:_____ Province:_____ Postal Code:_____
Telephone: _____(home) _____(work) _____(mobile)
Email address: _____ Do we have consent to email you? Y / N
Your email address will be kept confidential and will only be used to send pertinent information relating to the clinic.

Emergency Contact Name:_____ Relationship:_____
Telephone:_____(home) _____(work) _____(mobile)

2. **REFERRAL INFORMATION**

Family Physician:_____ Did they refer you directly to the clinic? Y / N
Referring Physician:_____ Did they refer you directly to the clinic? Y / N
If you were self-referred, how were you made aware of the clinic? (Please circle)
*Friend _____ *Internet Search *Our Website *The Yellow Pages *Other _____

3. **WORK-RELATED INJURY**

WSIB Claim Number:_____ S.I.N.:_____
Place of Employment:_____ Date of Injury:_____
Supervisor name:_____ Job Title:_____
Workplace Address:_____ City:_____ Postal Code: _____
Telephone:_____ Fax:_____
WSIB Adjudicator Name:_____ Telephone:_____
WSIB Nurse Case Manager:_____ Telephone:_____

4. **MOTOR VEHICLE ACCIDENT**

Accident Date:_____ Claim Number:_____ Policy Number:_____
Auto Insurance Company:_____ Adjuster's Name:_____
Auto Insurance Co. Address: _____ City:_____ Postal Code:_____
Auto Insurance Co. Telephone:_____ Fax:_____

5. **EXTENDED HEALTH BENEFITS**

Extended Health Insurance Company:_____
Policy Number:_____ ID Number:_____