INFOCUS REHABILITATION CENTRE INC.

PATIENT INTAKE FORM

Full Name: _____

Date of birth (dd/mm/yyyy): _____ / _____ / _____ Sex: M F

Street address: _____

City/Town: _____Postal Code:_____

Email address: _____
Telephone: (home) _____
(work) _____
(cell) _____
How did you find out about us_____

Name of Medical Doctor: _____ Phone #:_____

Are we billing on your behalf to a private insurance company? Y/N

Name of Insurance Company:_____

Plan/Policy #_____ **ID/Certificate#**_____

Name of Insured (Plan Holder):_____

Date of Birth (of the insured plan member):_____

*****If we are direct billing on your behalf to your private health insurance, you will be required to leave a credit card number on file for any amount not covered by your insurance plan. Clients are responsible for monitoring their own coverage per calendar year*****
Credit Card #:_____ Exp. Date:_____

Is this a Motor Vehicle Accident: Y/N
Name of Car Insurance Company_____
Policy #:_____ Claim#_____ Date of Accident_____
Name of Accident Benefits Adjustor:_____
Phone# _____ Fax#_____
Have you completed and returned your accident benefits package? Y/N
Do you have private insurance? Y/N Name of carrier:_____

********PLEASE NOTE, WE DO NOT ACCEPT/PROCESS WSIB CLAIMS********

#201-81 Todd Rd., Georgetown, ON L7G 4R8 W 905-702-7891 **F** 905-877-5547 infocusphysio@gmail.com