Good Health Wellness Centre

735 Davis Drive, Newmarket, ON L3Y 2R2
Tel: (905) 235-0133 **Fax:** (905) 235-0058

INITIAL INTAKE FORM

PLEASE PRINT

Date _____
(mm/dd/yyyy)

Welcome to Goodhealth Wellness Centre! 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.