ASSURED HEALTH
PHYSIOTHERAPY

New Patient Intake Form

First Name: _____ Last Name: _____ Male / Female

Birth date (Day/Month/Year):_____

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

Home Address: _____ City:_____

Postal Code: _____ E-Mail _____

Occupation: _____

Appointment Reminder: Email ☐ Phone Call ☐

►How Did You Hear About Us?

☐Doctor's referral ☐Flyer ☐Referral from Family or Friend

☐Walked by the clinic ☐Website ☐Other: _____

For ICBC Patients only

Claim #: _____ Date of MVA:_____

Adjuster Name: _____ Adjuster Phone#:_____

Lawyer Name: _____ Lawyer Phone#:_____

Lawyer Email:_____

Patient Signature:_____ Date:_____

If the patient is under 16 years of age or if mentally challenged, a parent or guardian must sign below.

I, _____ am the parent/guardian of the above named patient and I consent to examination and treatment of this patient.

Signature of parent/guardian: _____