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| **PERSONAL INFORMATION** |
| Name |
|  | First Name | Middle Initial | Last Name |  |
| Address |
| City |  | Province |  Postal Code |  |
| Home Phone  |  | Business Phone  |  |
| Cell PhoneI consent to appointment reminders via text: □ Yes □ No | E-MailI consent to appointment reminders via email: □ Yes □ No  |
| Date of Birth / / | □ Female | □ Male | □ Other |
|  Day Month Year |  |  |
| Date of Injury |  or □ gradual onset | Area of Injury |  |
| **Emergency Contact** |
| Name |
| Relationship to Patient Phone No. |
| **Guardian (for Patients under the age of 18)** |
| Name |
| Relationship to Patient Phone No. |
| **Physician(s)** |
| Family Physician Address Phone |
| Referring Physician Address Phone□ Same as Family Physician |
| **Employer Information** |  |  |
| Employer at time of injury |  | Phone No. |
| Address Supervisor Name:  |
| Current Employer□ Same as above | Phone No. |

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| **What most influenced your decision to choose Lifemark?** |
| * Family Doctor
* Medical Specialist
* Walk-in Clinic
* Dentist
 | * Employer
* Insurance Company
* Lawyer
* Rehab Consultant
 | * Friend / Relative
* Returning Patient/ Self
* Coach / Teacher
* Print Advertising
 | * Google / Internet
* Facebook
* Signage / Location
* Other:
 |
| Who can we thank for your referral? Name: |  |
| Address: |  |  |  |

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| **Motor Vehicle Accident (MVA) Patients Complete This Section** |
| Auto Insurance Company | Adjuster’s Name  |
| Address |
| Adjuster’s Phone | Adjuster’s Fax |
| Claim Number | Policy Number |
| Have you completed your Accident Benefits package (OCF-1)? □ YES □ NO | Policy Holder |
| Do you have Extended Healthcare Insurance through your employer or family member? □ YES □ NOIf yes, indicate which services your plan provides coverage for: □ Physiotherapy □ Massage Therapy □ Chiropractic □ Occupational Therapy □ Kinesiology |
| EHC Company | Plan Member Name |
| Policy/Plan No. | Certificate/ID No. |
| Benefit Year: Jan-Dec OR  | Additional EHC coverage? □ YES □ NO |
| 2nd EHC Company | Plan Member Name |
| Benefit Year: Jan-Dec OR | Plan Member Date of Birth |
| Policy/Plan No. | Certificate/ID No. |

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| **WSIB Patients Complete This Section** |
| Case Manager’s Name |
| Case Manager’s Phone | Case Manager’s Fax |
| Claim Number | First Date of Lost Work |

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| **OHIP / ODSP Patients Complete This Section** |
| Health Card No. | Version Code | Expiry Date |
| Are you on the Ontario Disability Support Program or Ontario Works? □ YES □ NO |
| If yes, case worker name & phone no. |

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| **For Office Use Only** |  |
| Patient Type | Program Type |
| Primary Therapist | Referral Date | Assessment Date |
| **MVA** – Verify Patient Photo ID □ Driver’s License □ Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **OHIP** - Health Card Verified □ Yes □ No **ODSP** - Benefit card/Statement of Assistance □ Yes □ No |