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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL INFORMATION** | | | | | | | | | |
| Name | | | | | | | | | |
|  | First Name | | | Middle Initial | | Last Name | | |  |
| Address | | | | | | | | | |
| City |  | | | Province | | Postal Code | | |  |
| Home Phone |  | | | Business Phone | | | | |  |
| Cell Phone  I consent to appointment reminders via text: □ Yes □ No | | | | E-Mail  I 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 □ NO  If 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 | | | |