

Body and Soul Physiotherapy Centre

Last Name _____	First Name _____	
Address _____		
City _____	Province _____	Postal Code _____
Tel _____	Bus _____	_____
Date of Birth _____	Referring Doctor _____	_____
How did you hear about us: friend € internet € other _____		
e-mail address _____		
PLEASE NOTE THAT WE ARE NOT AN OHIP CLINIC		

WORK RELATED INJURY?

S.I.N. # _____ OHIP # _____
Employer's Name & Address _____

Did the injury happen at work? YES € NO €
Did you report it to your employer? YES € NO €
Date of your injury (dd/mmm/yy) _____
Claim Number: _____

MOTOR VEHICLE ACCIDENT?

Date of the Accident (dd/mmm/yy) _____
Name of the Insurance Company _____
Policy Number _____ Claim Number _____
Adjuster's Name _____
Adjuster's Phone Number: () _____ Adjuster's Fax Number: () _____

EXTENDED HEALTH BENEFITS?

Do you have Extended Health Insurance? YES € NO €
Name of the Insurance _____
Policy/Group # _____
Certificate/Member ID# _____
Is the coverage through YOU € SPOUSE € PARENT €
Plan Member's Name _____ Date of Birth _____