

Please complete the following forms to allow us to get to know you and to provide the best possible care.

Please write clearly and in bold ink.

If you have any questions, or need assistance, please do not hesitate to ask.

Forms must be filled out by a parent/guardian if the client is under 18 years of age.

Personal Information

Last Name		First Name		Middle Init.	Preferred Name	
Birthdate <small>17/Jul/1977</small>		Marital Status		Email Address		
Home Ph#		Cell Ph#		Work Ph#		Work (ext.)
Address						
Apt#		City		Province		Postal Code

Whom may we thank for referring you to our clinic?

Do you prefer to receive your appointment reminders and correspondence by email?

YES

NO

Emergency Contact

Name	Ph#	Relationship
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Insurance Information

Name of Policy Holder		Policy Holder's Birthdate <small>17/Jul/1977</small>	
Policy Holder's Employer Name		Relationship to Policy Holder: Self Spouse Child Common Law Other	
Insurance Plan Name		Group#	Cert/ID#

Do You Have a Secondary Insurance Plan? If so, please fill section below.

Name of Policy Holder		Policy Holder's Birthdate <small>17/Jul/1977</small>	
Is Policy Holder a Client?		Policy Holder's Address	
Policy Holder's Employer Name		Relationship to Policy Holder: Self Spouse Child Common Law Other	
Insurance Plan Name		Group#	Cert/ID#