THE REHAB CENTRE
Maple's premier rehab and wellness centre

Patient Introduction *(Please Print)*

Name: _____ _____ Gender: Male ☐ Female☐
First *Last*
Date of Birth: (Year) _____ (Month) _____ (Day) _____
Home Address: _____
City _____ Province _____ Postal Code _____
Home Telephone: ( ) _____ Cell Number: ( ) _____
Work Telephone: ( ) _____ Email: _____

REFERRED BY: _____

DOCTOR INFORMATION:
Doctor name: _____ Address: _____
Telephone: ( ) _____ Fax: ( ) _____

AUTO/WORK ACCIDENT INFORMATION:

Is this a due to a Car Accident? Yes ☐ No ☐ Is this due to a Work Accident? Yes ☐ No ☐
Date of Accident: (Year) _____ (Month) _____ (Day) _____
Name of Insurer: _____
Name of Adjuster: _____
Telephone: ( ) _____ Fax Number: ( ) _____

Employer Name: _____ **Employer Contact:** _____
Job Title: _____ **Phone Number:** ( ) _____

Have you been to any other Rehab Clinic: Yes ☐ No ☐ If yes, date of first and last Visit:

_____ _____
Law Firm: _____ Contact: _____
Telephone: ( ) _____ Fax Number: ( ) _____

EXTENDED HEALTH INSURANCE COVERAGE:

Name of the Insurance Company: _____
Policy Holder's Name: _____
Relationship to Policy Holder: _____ Policy Holder's Date of Birth: _____
Policy/Plan # _____ Group ID # _____ Certificate # _____

VISA ☐ MasterCard ☐ Card Holder Name: _____
Card Number: _____ Expiry Date: _____ CVS Code: _____