PROMED Rehabilitation clinic

PATIENT INFORMATION FORM

GENERAL INFORMATION: Last First Middle

NAME: (Mr.Mrs.Ms) _____ DATE OF BIRTH :____/____/____

ADDRESS: _____

POSTAL CODE: _____ TEL:_____ CELL_____

DRIVERS LICENSE:_____ S.I.N:_____

HEALTH INSURANCE (OHIP):_____

REFERRING PHYSICIAN:_____ TEL:_____

EMPLOYERS NAME: _____ TEL:_____

PRIVATE (GROUP) HEALTH INSURANCE/EXTENDED HEALTH PLAN PARTICULARS:

INSURANCE COMPANY: _____

ID/CERT.:_____GROUP/POLICY:_____

POLICY HOLDER:___ _____DATE OF BIRTH:____/____/____

MOTOR VEHICLE ACCIDENT CASE:

DATE OF ACCIDENT: ____/____ /____ mm dd yy POLICY:_____CLAIM:_____

POLICY HOLDER: _____TEL:_____

INSURANCE COMPANY:_____ _____

INSURANCE COMPANY ADDRESS: _____

ADJUSTER'S NAME: _____ TEL:_____

LAWYER'S NAME:_____ TEL:_____

WSIB

WSIB CLAIM:_____ DATE OF ACCIDENT:_____/____/____

EMPLOYER'S NAME/ADDRESS:

_____

SUPERVISOR: _____TEL:_____

ADJUDICATOR:_____ TEL: _____

NURSE:_____TEL:_____