advantage physiotherapy
& sports injury clinic

PATIENT INFORMATION

Patient's Name	**Gender** F M	**Date**
Address (Street/Apt) **(City)** **(Postal Code)**		
Home Telephone	**Cell Phone**	**Work Telephone**
Email Address (for appointment reminders)		**Occupation**
Guardian Name and Phone number **(if under 18 years of age)**	**Family Physician**	**Date of Birth**

How did you hear about us?

□ Physician
□ Family/ Friend: _____
□ Other: _____
□ Phonebook_____
□ Internet ____
□ Have been here previously

MOTOR VEHICLE ACCIDENT INFORMATION

Extended Health Care Plan (if applicable)

Insurance Company	**Telephone Number**	**Policy Holder Name**
Policy or Group #	**ID #**	**Date of Birth of Policy Holder**
Secondary Insurance Company (spouse)	**Telephone Number**	**Policy Holder Name**
Employer	**Policy or Group #** **ID #**	**Date of Birth of Policy Holder**

Auto Insurance Plan

Insurance Company	**Telephone Number**	**Fax Number**	**Policy Holder Name**
Address (Street/ Suite) **(City)** **(Province)** **(Postal Code)**			**Date of Accident**
Adjuster's Name	**Claim #**		

***Please Note for MVA's**: The provincial auto insurance legislation as outlined by the Statutory Accident Benefits Schedule (SABS), states, "Payment of a medical, rehabilitation or attendant care benefit or a benefit under PART IV is not required for that portion of an expense for which payment is reasonable available to the insured person under any insurance plan or law or under any other plan or law. O. Reg. 34/10, s. 47 (2)."*
(By law we must exhaust funds from your **Extended Health Care Plan** prior to using your **Auto Insurance Plan**)