Guelph Rehab Centre
INNOVATIVE HEALTHCARE

Patient Intake Form

☐ MVA ☐ WSIB ☐ Private Date: _____

Please print clearly. If you have any questions, please do not hesitate to ask. Thank you.

Client Name:
FIRST NAME INITIAL LAST NAME

Address: **Email:**

City: Province: Postal Code:

Home Phone: ( ) **Cellular Phone**: ( )

Date of Birth: / / Gender: ☐ Male ☐ Female
DAY MONTH YEAR

What brought you to Guelph Rehab Centre? (*Please select one*)

Direct Referral by: (please complete next section)
☐ Family Physician
☐ Specialist (Please specify: _____)
☐ Employer
☐ Insurance Company
☐ Lawyer
☐ Rehab Consultant
☐ Health Bound

Self Referral
☐ Brochure (source _____)
☐ Family / Friend
☐ Window Signage
☐ Returning Patient
☐ Website
☐ Bus Advertisement
☐ Radio Commercial
☐ *Other*: _____

Family Physician or Specialist Information ☐ same as **Referral Source** above

Doctor Name:
SALUTATION FIRST NAME INITIAL LAST NAME

Address:

City: Province: Postal Code:

Phone: ( ) Fax: ( )

☐ Emergency Contact or ☐Guardian (for minor patients)

Name:
FIRST NAME INITIAL LAST NAME RELATIONSHIP

Phone: ( )

Payment Responsibility

I understand that I am responsible for all fees incurred at Guelph Rehab Centre; this applies also to Motor Vehicle Accident and WSIB claims. I consent to Guelph Rehab Centre billing all insurance for treatment on my behalf; I agree to pay for any outstanding fees on my account that my insurer may not cover. I am aware of the 35.00 fee for missed or cancelled appointments without 24 hours' notice.

_____ _____
Signature **Date**