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

**Extended Health Care**
Company: _____ Name on Card: _____ DOB:_____

Policy: _____ID: _____

**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**