DALHOUSIE Physiotherapy Clinic

Patient Information

First Name: _____ Last Name: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary **Date of Birth:** Day___ Month___ Year_____

Family Physician: _____
Occupation: _____
Employer/School: _____

☐ Student #_____
☐ Dalhousie Varsity Athlete
Team: _____

Permanent Address:

Street					
City		Province		Postal Code	

Local Address: (leave blank if same as permanent address)

Street					
City		Province		Postal Code	

Telephone numbers:

Please check (√) preferred method of contact		√
E-mail		
Mobile phone		
Home phone		
Work phone (Ext).		

Method of referral:

☐ Internet ☐ Occupational health ☐ Self ☐ Another patient ☐ Coach ☐ Trainer
☐ Another health care provider ☐ Student Health ☐ Other ☐ Family physician ☐ Specialist
Please indicate who referred you to us: _____

Insurance information:

Primary Insurance Provider: _____ ☐ Dal student Coverage

Plan/Policy #: _____ Plan ID #: _____
Primary Card Holder: _____ Relationship: _____

Signature: _____

Signature: _____ **Date:** _____
(Guardian if under the age of 18)