

Patient Intake Form



Demographic & Contact information

First name: _____ Last name: _____ Birth Date: _____
(dd/mm/yyyy)

Gender: Male Female Non-Binary

Dal Student # _____
 Kings Student # _____
 Dal Varsity Team _____
 Dal Club Team _____

o Address: _____ City: _____
Prov: _____ Postal Code: _____ Permanent Local

o Email: _____

o Home (p): _____ Cell (p): _____ Work (p): _____

o Occupation: _____ Employer/School: _____

o Family Physician: _____

Method of referral:

Internet Social Media another Patient Coach Trainer Dal Student Health
 Health care provider Family Physician Specialist Other: _____

Insurance Information

The DPC can direct bill most insurance companies!

Primary Insurance provider: _____ Dal Occupational Health?

Plan/Policy #: _____	Plan ID#: _____	<input type="checkbox"/> Dal student Coverage
Primary Card holder: _____	Relationship: _____	<input type="checkbox"/> Kings Coverage

Will your insurance be going through a Motor Vehicle Accident? Yes

Insurance: _____	Claim #: _____	Date of accident: _____
Case Manager: _____	E-mail: _____	(P): _____

Signature: By signing below, I certify that all information above is correct and true to best of my knowledge. I also understand and agree that I am responsible to pay any outstanding balance on my account after each session; as these treatments are not covered by provincial health care.

Signature: _____

Parent/Guardian Signature: _____
(If under the age of 18)

Date: _____