METROTOWN FAMILY CHIROPRACTIC

Last Name, First Name			Email Address		
Is this your preferred name? ❑ Yes ❑ No		If No, please indicate your preferred name.	Birth date (MM.DD.YR)	Age:	Sex: ❑ M ❑ F
Home address:		Home Phone Number: ( )	Cell Phone Number: ( )		
City:	Province:	Postal Code:	Personal Health Number (PHN):		
Occupation:	Employer:		Work Phone Number ( )		
Referred to clinic by (please check one box):	❑ Dr. _____		❑ Google	❑ Yelp	
❑ Friend/Family Member: _____	❑ Close to home/work	❑ Yellow Pages	❑ Other: _____		

Family Physician Name:

Family Physician's Clinic Name and/or Phone Number:

EXTENDED HEALTH INFORMATION

Extended Health Insurance Provider: ❑ Great West Life ❑ Sunlife ❑ Blue Cross ❑ Manulife ❑ Other: _____

Extended Health Card Number:

Name of the Primary Card Holder:

Primary reason for visit (Please Describe):

Is today's visit related to a motor vehicle accident or workplace injury?
❑ Yes
❑ No

If YES, please list the following -

Date of the Accident:

Claim Number:

Adjuster Name:

Adjuster Phone Number:

EMERGENCY CONTACT

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

MISSED APPOINTMENT POLICY/MSP ASSIGNMENT

I understand that I am financially responsible for medical services provided to me and missed appointments. If I am unable to keep an appointment, I must provide the clinic at least 24 hours' notice to cancel otherwise the full amount of the treatment will be invoiced. There are two ways to modify/cancel an existing appointment:

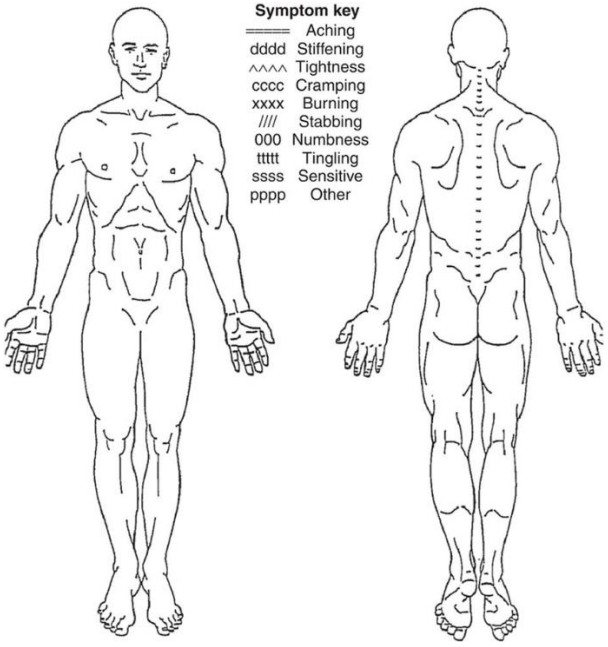
1. **Visiting our website and utilize our online booking platform** www.metrotownchiropractic.com
2. **Email** info@metrotownwellness.com **or Call 604-430-1525**

I authorize Medical Services Plan to pay Metrotown Family Chiropractic directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me at this clinic. I make this assignment in full knowledge of the amount that I will personally be responsible for and the amount that is reimbursable by the Medical Services Plan which will be directed to Metrotown Family Chiropractic to be applied against any outstanding monies I owe for services provided.

By Signing below, I consent to the "Missed Appointment Policy" + "MSP Assignment"

Patient/Guardian signature *Date*

Please Indicate the Location of your Complaint



HEALTH QUESTIONNAIRE

Please list any medications you currently take:

Do you have a history of cardiovascular disease, or any other medical conditions?

Have you ever had any fractures? If yes, where and when?

Do you suffer from headaches?

Have you sought previous therapy for this complaint? (eg. Physiotherapy)

Please add any additional comments: