METROTOWN FAMILY CHIROPRACTIC

CUSTOM ORTHOTICS INTAKE FORM

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:	Gender Pronoun: ❑ He ❑ She ❑ They
Home address:	Phone Number and Carrier ( )	❑ Telus ❑ Rogers ❑ Bell ❑ Other: _____		
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 ❑ Other: _____

Family Physician Name: _____

Family Physician's Clinic Name:_____

Phone Number:_____

EXTENDED HEALTH INFORMATION FOR DIRECT BILLING

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

Extended Health Card Number: _____ Policy Number: _____

Name of the Primary Card Holder: Birthday of Primary Card Holder (MM.DD.YR):

_____ _____

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 (MM.DD.YR): _____

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:

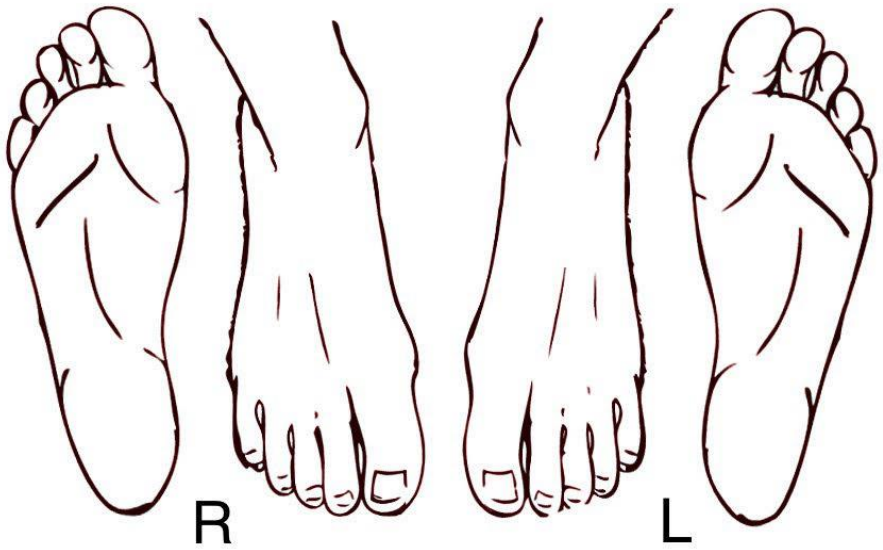
1. **Visiting our website and utilize our online booking platform (www.metrotownchiropractic.com)**
2. **Email info@metrotownwellness.com or Call 604-430-1525**

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



ADDITIONAL INFORMATION FOR ORTHOTICS

Weight:
Height:
Shoe Size:
Type of shoes: (eg Runners, Dress Shoes, Safety Boots, Casual)
Chief Complaint: .