THE SPORTS CLINIC

NEW PATIENT INFORMATION

Nature of Injury: ____________________

Last Name: ____________________

Date of Birth (YY/MM/DD): ____________________

Health Card Number: ____________________

Address: ____________________

City / Province: ____________________

Postal Code: ____________________

Occupation: ____________________

First Name: ____________________

Gender: ☐ Male ☐ Female

Home Phone: ____________________

Mobile Phone: ____________________

Business Phone: ____________________

Email: ____________________

☐ I accept email reminders for my appointments

FAMILY PHYSICIAN

Name: ____________________

Address: ____________________

City / Province: ____________________

Phone: ____________________

Fax: ____________________

Last Visited: ____________________

REFERRED BY

☐ Family Doctor: ____________________

☐ Other Referring Doctor: ____________________

☐ Team / Organization: ____________________

☐ Word of Mouth

☐ Web

☐ Advertising / Brochure

PATIENT AGREEMENT

1. I understand that it is my responsibility to provide accurate and current information about my medical history.
2. I understand and acknowledge the fees for services rendered by any provider of The Sports Clinic.
3. I understand it is my responsibility to cover the full cost of the treatment. If I have extended benefits I will pay on the days of service and seek reimbursement through the insurance company unless otherwise agreed. In the event that I am attending the clinic due to injuries sustained in a motor vehicle accident and the insurance is billed on my behalf, I will remit all payments received for services rendered to The Sports Clinic.
4. I acknowledge that all outstanding balances must be paid prior to my discharge from a treatment program.
5. I acknowledge the late cancellation and missed appointment policy. I agree to pay for the time blocked off for me should I not provide 24 or more hours notice.

Patient / Guardian's Name: ____________________

Signature: ____________________

Date: ____________________

Emergency Contact: ____________________

Phone: ____________________

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THE SPORTS CLINIC

NEW PATIENT INFORMATION

Is this a result of a car accident? ☐ Yes ☐ No

IF YES: Claim #: ____________________ Date of Accident: ____________________

Extended/Private Insurance Company: ____________________

Auto Insurance Company: ____________________

Adjuster Name: ____________________

Adjuster Phone: ____________________ Adjuster Fax: ____________________

IDENTIFY ANY CARDIOVASCULAR ISSUES

Blood Pressure (high/low) ☐ Yes ☐ No

Cholesterol (high/low) ☐ Yes ☐ No

Palpitations ☐ Yes ☐ No

History of heart disease or stroke ☐ Yes ☐ No

Pacemaker or similar device ☐ Yes ☐ No

IDENTIFY ANY PULMONARY ISSUES

Do you smoke? ☐ Yes ☐ No

If yes, for how long? ____________________

Asthma ☐ Yes ☐ No

History of bronchitis or pneumonia ☐ Yes ☐ No

IDENTIFY ANY OTHER MEDICAL ISSUES

Bleeding disorders (i.e. hemophilia, sickle cell, etc.) ☐ Yes ☐ No

Diabetes – Type I or Type II ☐ Yes ☐ No

Bowel or bladder problems ☐ Yes ☐ No

History of cancer ☐ Yes ☐ No

Currently pregnant or possibly pregnant ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Dizziness ☐ Yes ☐ No

Difficulty speaking ☐ Yes ☐ No

Double vision ☐ Yes ☐ No

Difficulty swallowing ☐ Yes ☐ No

Suddenly falling (i.e. legs giving out) ☐ Yes ☐ No

Previous surgeries ☐ Yes ☐ No
... if yes, please list

____

____

List previous injuries and when sustained:

____

____

List any medication you are currently taking:

____

____

The Sports Clinic
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