PINNACLE PHYSIOTHERAPY OF WINDSOR - PATIENT INFORMATION

Last Name:	First Name:	Gender: ❑ Male ❑ Female	Date of Birth: (yy/mm/dd)
Address:	City:	Postal Code:	Phone:
E-Mail address:		Would you like appointment reminders by email? ❑ Yes ❑ No	
How did you hear about us?			Photo ID? ❑ Checked Admin Initials:

Area of Injury:	Date of Injury:
Family Physician:	Referring Physician/Script Date:

EMERGENCY CONTACT:

Name & Relationship:	Phone Number:

ASSESSMENT INFORMATION: (Office Use Only)

Date of Contact:	Date of Appointment:	Time of Appointment:	Therapist:

Additional Information/Contacts: _____

_____

_____

CONSENT TO RELEASE/OBTAIN INFORMATION

I, _____ give consent to Pinnacle Physiotherapy to:
(Please PRINT full name)

_____ **Release copies of reports regarding my treatment, progress and discharge to the individual(s) and**
(Initials) **establishment(s) named below.**

_____ **Contact individuals named below to obtain verbal or written information in regards to my injury, disability,**
(Initials) **functional and employment needs as applicable.**

_____ _____ _____
Family Physician Referring Physician Specialist

_____ _____ _____
Insurance Company WSIB (Name of Contact) Employer

I have read and understand the authorization and hereby give consent by my signature below:

_____ _____
Signature **Date**