MAX PHYSIOTHERAPY **Patient Registration Form**

PATIENT DETAILS

FIRST NAME _____ **LAST NAME** _____

ADDRESS _____

HOME PH. _____ **CELL** _____

EMAIL _____

ALBERTA HEALTH CARE NUMBER _____

EMPLOYER _____ **OCCUPATION** _____

DATE OF INJURY _____ **AREA OF INJURY** _____

MOTOR VEHICLE ACCIDENT YES / NO **WCB CLAIM** YES / NO

CLAIM NUMBER _____ **EMPLOYER AT TIME OF INJURY** _____

POLICY NUMBER _____ **INSURANCY COMPANY** _____

ADJUSTER NAME _____ **ADJUSTER FAX #** _____

EXTENDED HEALTH CARE INFORMATION

INSURANCE COMPANY _____ **COVERAGE LIMIT** _____

POLICY/ PLAN NUMBER _____ **CERTIFICATE / ID #** _____

PHYSICIAN/ EMERGENCY CONTACT

FAMILY PHYSICIAN _____ **PHONE** _____

EMERGENCY CONTACT NAME _____ **PHONE** _____

WOULD YOU LIKE TO REFER YOUR FRIEND/FAMILY TO MAX PHYSIOTHERAPY?

NAME _____ **PHONE** _____