36 Pine Street South • Timmins, ON • P4N 2J8 • (705) 268-9099 • timminschiro@gmail.com

# New Patient Form

**Welcome to Timmins Chiropractic Clinic. Please take a moment and tell us about yourself.**

**Name:** Mr. Mrs. Ms. Dr.

Last name: ______________________ First Name: ______________________
Date of birth: Day _______ Month________ Year___________
Address:_____________________________________________________________
_________________________________________________________________
City: ___________________________ Postal Code: _______________
Phone: ( ) ______________________ Work: ( ) _______________________
Email address: ____________________________________________________
Occupation: ______________________________________________________
Emergency contact: _______________________ Relationship: _____________
Emergency Contact Phone: ( ) ______________________________________

## Previous Chiropractic

Have you received chiropractic before? Yes No
Previous chiropractor:_________________________________________________
Date of last visit: ___________________________________________________

## Family Doctor/Nurse Practitioner

Family Doctor/ Nurse Practitioner's name: _____________________________
MD's/NP's Telephone: ________________________________________________

**How did you hear about us?**

We are pleased that you have chosen to come and see us! Please take some time to let us know how you found out about Timmins Chiropractic Clinic.

Newspaper Internet Yellowpages Signage Friend or relative

Referral: ______________________ Other: ___________________________

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### Billing Information

### Type of Injury

Is this a Workplace Safety & Insurance Board injury? ☐ Yes ☐ No
(If not, you do NOT need to fill in the following information).

WSIB Claim No. ________________ Date of accident: _________________
Employer's name: ____________________________________________
Employer's Address: __________________________________________
Employer's Telephone: ________________________________________

### Type of Injury

Are your injuries related to a motor vehicle case? ☐ Yes ☐ No
(If no, you do NOT need to fill in the following information).
Date of accident: ______________________________________________
Insurer's name: ________________________________________________
Policy or claim #: ______________________________________________
Insurer's address and telephone: __________________________________

### Consent

I agree and understand that I am responsible for all charges relating to my visit.

Date: ________________________ Signature: ________________________

Date: ________________________ Guardian: ________________________
(If patient is under 18 years of age).

**Please note:**

**All accounts are the responsibility of the patient. Your supplemental or extended health care insurance plan may provide coverage for massage services. We will issue a receipt for each payment for this purpose.**