HEART LAKE CHIROPRACTIC CLINIC

10425 Kennedy Road , Suite 205
Brampton, Ont L6S 0A4 905-840-1330

CONFIDENTIAL PATIENT INFORMATION

Name: _____

Address: _____

City: _____ Postal Code: _____

Phone: home _____ business: _____

cell: _____ email: _____

Birthday: Month:_____ Day:_____ Year:_____ Gender: M / F

Marital Status: M / D / W / S Do you have an MRI? Y / N

Children: # _____ Spouse: _____

Employer: _____Address:_____

Chief Complaint: _____

Referred by: Patient? _____Ad? _____ Doctor? _____

Is this a motor vehicle accident case? Y/N Is this a WSIB case? Y/N

FAMILY DOCTOR: _____ Phone _____

Address: _____

I understand and agree that health and accident insurance policies are an arrangement between myself and my insurance carriers. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. **I also understand that if I suspend or terminate treatments, all outstanding balances will be immediately paid in full.**

_____ _____

Signature Date

PLEASE SIGN, DATE ALL FORMS.
PLEASE ANSWER ALL QUESTIONS ON ALL FORMS.

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