Acton – Burlington - Elora – Hespeler - HPC – Georgetown – Guelph – Orangeville - Waterloo

Thank you for choosing EPA to assist you with Your Path to Improved Health

PLEASE PRINT

Name_____ **Address**_____ **City/postal code** _____

DOB(mm/dd/yy)_____ **Home #**_____ **Work or cell #** _____

Referring MD _____ **Family MD** _____

Emergency contact _____ **Emergency #**_____

Email address _____

To assist you in managing your schedule we will use **your email for appointment reminders**, as well as clinic newsletters, updates or promotions. I*f you do not wish to receive newsletters or promotions please note that you can opt out of this function the first time that you receive a clinic update.*
Consent to use email (please initial) ☐

How did you hear about our clinic (please circle one)

You are our previous client Doctor Friend Family Word of Mouth

Twitter Linked In Google Facebook EPA Website

Our location EPA sign Phone Book Yellow Pages online Rink Board

Newspaper Chamber of Commerce Your Workplace: _____

Other_____

At Eramosa Physiotherapy Associates, we pride ourselves in customer service. Please do not hesitate to speak to our knowledgeable administration staff or physiotherapist about any coverage or billing concerns. Please note that most insurance companies will not release the details of your coverage, and as a result we strongly encourage you to contact them for exact details of your coverage.

Insurance Coverage: Please circle applicable

- **Extended Health co (name)**_____

*We are able to offer the convenience of direct billing to many insurance companies. We will notify you if we are able to direct invoice your insurance company
Name and DOB of insurance holder: _____**DOB(d/m/yr):** _____

- **MVA or WSIB (we will provide you with more detailed information necessary for successful claim submission)**
- **Self-Funded**

(please turn page to complete more information)

Confidential Medical History

Please check those that apply to you to help ensure that we understand any critical areas of your medical history.

___ Latex Allergies

Head and Neck
____Headaches
____Migraines
____Glasses

Respiratory
____Chronic Cough
____Shortness of Breath
____Smoke
____Asthma
____Breathing problems

Digestive
____Difficult digestion
____Constipation
____Liver/Gall bladder
____Diabetes
____I.B.S

Cardiovascular
____high/low B.P
____poor circulation
____Heart disease
____Phlebitis
____Varicose Veins

Skin
____Bruise easily
____Skin conditions

Other conditions
____Sinus
____Insomnia
____Cancer/type
____Arthritis/type
____Epilepsy
____Seizures
____Pregnancy
____HIV

Have you had any surgeries?

Surgery Type	Date	Ongoing symptoms

Current Medications: or attach a copy from your pharmacy

Medication Name	Reason for Medication