FAMILY Physiotherapy CLINIC

Name _____
Mailing Address _____
Home phone _____
Cell Phone _____
E-mail _____
Date of Birth _____
Emergency Contact _____ Phone # _____
Family Physician's name _____
address _____
phone _____
Specialist's name _____
address _____
phone _____
Why do you need treatment today? _____
Do you have a physician's referral? yes no

Do you have insurance coverage? yes no

Type of insurance (please check one)	**Plan/Claim numbers**	
❑ Manitoba Public Insurance (Autopac)	Claim #	
	Accident Date	
	Case Manager	
	Case Manager's Ph. #	
❑ Workers Compensation Board	Claim #	
	Accident Date	
	Case Manager	
	Case Manager's Ph. #	
❑ Blue Cross	Group # :	Contract #:
	% coverage:	Annual max:
❑ Great West Life	Plan # :	Employee ID #:
	% coverage:	Annual max:
	Deductible? Yes No	Amount:
❑ Other:		
	% coverage	Annual max: