



Information Sheet

Chart #: _____

Provider: _____

Today's Date: _____ Doctor's name on referral: _____

Last Name: _____ First Name (s): _____

Preferred Name (if different from above): _____

Male Female Date of Birth: D _____ M _____ Y _____

Local Address: _____

City: _____ Postal Code: _____ Home Phone: _____

Cell Phone: _____ Business Phone: _____ ext. _____

Permanent Address (if Different From Above): _____

City: _____ Postal Code: _____ Phone #: _____

Ontario Health Card Number: _____ **Version:** _____

Expiry Date: D _____ M _____ Y _____

Out of Province Health Card Number: _____

Family Doctor: _____ City: _____

Allergies: _____

Medical Problems: _____

Medications: _____

How did you hear about WSM?

- | | |
|---|--|
| <input type="checkbox"/> Doctor | <input type="checkbox"/> Coach/trainer/teammate/manager, etc. |
| <input type="checkbox"/> Family/friend/co-worker/teacher/prof | <input type="checkbox"/> Phonebook/yellowpages/ad/sign/drive by |
| <input type="checkbox"/> Website | <input type="checkbox"/> Clinician (PT, RMT, NP, AT, Chiro., etc.) |

STUDENTS:

Elementary/High School: _____

Mother's Daytime Phone: _____ Father's Daytime Phone: _____

UW WLU Conestoga College Student Number: _____

Please provide an email address if you wish to receive our Athlete's Edge Newsletters via e-mail:
