



WATERLOO SPORTS MEDICINE CENTRE

Information Sheet

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 #: _____

Email: _____

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

Expiry Date: D _____ M _____ Y _____

Family Doctor: _____ City: _____

Allergies: _____

Medical Problems: _____

Medications: _____

Emergency contact name: _____ **Relationship:** _____

Phone: _____

How did you hear about WSM RIM Park? Please name the person where possible.

- Doctor _____ Phonebook/Ad
- Coach/trainer/teammate/manager _____ Website
- Family/friend/co-worker/teacher _____ Walk-by in RIM Park
- Clinician (PT, RMT, Chiro., etc.) _____ Other WSM Location

Please check if you wish to receive our Athlete's Edge newsletter and clinic updates by email