WATERLOO SPORTS MEDICINE CENTRE
...so you can play!

Information Sheet

Chart #: _____

Provider: _____

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

Last Name: _____ First Name (s): _____

Preferred Name: _____ Date of Birth: D _____ M _____ Y _____

Local Address: _____

City: _____ Postal Code: _____ Home Phone:_____

Cell Phone: _____ Business Phone:_____ ext._____

Email for appointment reminders: _____

Permanent Address *(if Different From Above)*: _____

City: _____ Postal Code: _____ Phone #:_____

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

Expiry Date: D _____ M _____ Y _____ ❒ Male ❒Female

Out of Province Health Card Number: _____

Province:_____

Family Doctor:_____ City: _____

Allergies: _____

Medical Problems: _____

Medications: _____

How did you hear about WSM?

❒ Doctor
❒ Family/friend/co-worker/teacher/prof
❒ Website
❒ Coach/trainer/teammate/manager, etc.
❒ Phonebook/yellowpages/ad/sign/drive by
❒ Clinician (PT, RMT, NP, AT, Chiro., etc.)

Post Secondary Students:

❒ UW ❒ WLU ❒ Conestoga College ❒ Other _____

Student Number: _____

Elementary/High School Students:

Parent's Name: _____ Daytime Phone: _____

Parent's Name: _____ Daytime Phone: _____