Rutland Physical Therapy Inc.
Patient Information

Name: _____ _____ _____
First Initial Last

Address: _____ City_____ Prov____ Postal Code _____

Phone # (H)_____ (W)_____ (Cell) _____

Email address _____

Date of Birth: Month ___ Day ___ Year ___Family Physician: _____

Occupation _____ Employer _____

Please fill out the appropriate section as to who your insurer is

MSP **"Supplementary Benefits"**	**ICBC**	**WCB**
Care Card Number: _____	*Care Card Number:* _____	*Care Card Number:* _____
	Claim Number: _____	*Claim Number:* _____
Did you have any of the following in this calendar year? How many visits?	*Adjuster's Name:* _____	*WCB Case Manager's Name:* _____
Physiotherapy _____	*Date of Accident:*	*Date of Incident:*
Chiropractic _____	Month ___ Day ____Year____	Month ___ Day ____Year____
Massage Therapy _____	*Lawyer's Name & Phone #:*	*Employer Contact & Phone #:*
Naturopath _____	_____	_____
Podiatrist _____	_____	_____

Medical History

Heart Conditions _____ Metal Implants _____ Arthritis _____ Cancer _____

Medications_____ X-rays/ CAT Scan/ MRI _____

Previous Surgeries_____ Previous motor vehicle accidents _____

Cancellation Policy

I am aware that if I am unable to keep my appointment, I must notify the clinic at least 24 hours prior to the appointment, or I will be charged a **$40.00** fee.

X _____
Signature of Patient

Payment of Fees

I understand that I am responsible for full payment of all treatments received at Rutland Physical Therapy Inc.

X _____
Signature of Patient