Taag Rehab

59 Gordon Randle Drive, Brampton, ON L6P 4H8
Phone: (647) 739-2802
Email: taagrehab@gmail.com

INITIAL INTAKE FORM

PLEASE PRINT

Date 19

Welcome to Taag Rehab Inc.! In order to serve you better, please take a moment to complete this form. If you require assistance, please see the receptionist. When finished, kindly return this form to the front desk.

Have you ever been a patient here before? ☐ Yes ☐ No If Yes, when?

How did you learn about us? (if referred, please name the referral)

Patient Information (please complete all of the fields below)

Last Name	First Name		Intl.
Street Address			Home Tel.
City/ Town	Province	Postal Code	Work Tel.
Date of Birth	Gender ☐ M ☐ F		Mobile
Email			
Name of Emergency Contact	Relationship		Emergency Contact Tel.
Name of Family Doctor			Family Doctor Tel.

Case Information (please indicate the reason for your visit and complete all of the related information)

☐ Automobile Accident

Date of Accident _____ Name of Automobile Insurance Company _____

Have you already reported your injuries to the insurance company? ☐ No ☐ Yes

Were you employed at the time of the accident? ☐ No ☐ Yes

Do you have a legal representative?

☐ No ☐ Yes (please provide name) _____

Do you have Extended Health Care benefits coverage?

☐ No ☐ Yes (please provide name of insurer)

☐ Work Injury

Date of Accident _____ Claim No. (if known) _____ File No. (if known) _____

First/Last Name Tel/Fax

☐ Slip & Fall

Date of Accident _____ Claim No. (if known) _____ File No. (if known) _____

☐ Sports Injury

Date of Accident _____ Claim No. (if known) _____

☐ Other _____

Patient Signature (please print your name, date and sign)

To the best of my knowledge, I certify that the information provided above is true and correct.

Name of Patient	Signature	Date

Please present the following documents:

☐ Driver's License ☐ Health Card (OHIP) ☐ Police Report ☐ Insurance Pink Slip ☐ Extended Health Benefits Card ☐ Other _____

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