Yarmouth Physiotherapy Inc.

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Phone: (902) 881-1515 Fax: (902) 881-1313
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Massage Therapy Client General Information Sheet

Last Name: _____ First: _____ Middle: _____

Home Phone #: _____ Cell: _____ Work : _____

Date of Birth: _____ Sex: (M/F): _____

Address: _____

_____ Postal Code: _____

Email Address (Optional. For appointment reminders): _____

Provincial Health Card #: _____

Name of Employer/School: _____

Occupation: _____

Family Doctor: _____ Referred by: _____

Are you involved in legal action involving your present injury? _____

If Under 18 Years (A parent/guardian must consent to assessment and treatment)

Guardian Name: _____

Guardian Address: _____

Guardian Phone #: Home _____ Cell _____ Work _____

Please indicate any health insurance funder who will be reimbursing you for your treatments (check more than one if applicable)

- ☐ Medavie Blue Cross
- ☐ Great West Life
- ☐ Green Shield
- ☐ Worker's Compensation Board / Claim #. _____
- ☐ Insurance company (Motor Vehicle)
- ☐ Other _____
- ☐ Self
- ☐ Veteran's Affairs Canada K #: _____

Private Medical Plan information (Blue Cross…):

Policy Holder's Full Name: _____ Date of Birth: _____

Policy Number: _____ I.D. #: _____

Policy Holder's Address: _____

Postal Code: _____ Phone #: _____

Policy Holder's relationship to you: _____

Is there a maximum amount or number of treatments covered (describe): _____

What percentage does this funder cover? _____ 100% _____ less than 100%