GIDDA · MEDICAL · WELLNESS

CHIROPRACTIC | FAMILY & AESTHETIC MEDICINE | REGISTERED MASSAGE THERAPY

REGISTRATION INTAKE FORM

(Please Print)

PATIENT INFORMATION

Last name:	First name:	Middle name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

Is this your legal name? ❑ Yes ❑ No	If not, please indicate your legal name:	Birth Date: DD/MM/YY / /	Age:	Sex: ❑ M ❑ F ❑ Other

Residential Address:	City:	Postal Code:

Home Phone: ( ) -	Cellular Phone: ( ) -

Which is your preferred phone number? ❑ Home ❑ Cellular

May we leave messages on your preferred phone number? ❑ Yes ❑ No

Email Address:

Health Card Number & Two Letter Version Code

____ ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____ ____

Referred to clinic by (please check all that apply): ❑ Dr. _____ ❑ Insurance Plan ❑ Friend

❑ Family ❑ RMT ❑ Location ❑ Online ❑ Other: _____

If applicable, please list other family members or friends seen by any provider at Gidda Medical Wellness:

PERSONAL HEALTH HISTORY

Past Medical History: (diagnoses)	
Past Surgical History: (please include year)	
Hospitalizations / Injuries / Trauma / Motor Vehicle Accidents: (please include year)	
Family History: (please include relationship to you and family member's diagnoses)	

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Medications: (prescription, vitamins, supplements and over the counter medications)	
Allergies: (include reaction to allergen)	
Social History:	Do you smoke? ❑ Yes ❑ No If yes, how much per day? _____ When did you start smoking? _____ If no, did you ever smoke? ❑ Yes ❑ No When did you quit? _____ Do you drink? ❑ Yes ❑ No If yes, how many drinks per week? _____When did you start drinking?_____ If no, did you ever drink? ❑ Yes ❑ No When did you quit? _____ Do you use any recreational drugs (ex. Marijuana, cocaine, heroin, ecstasy, PCP, LSD, amphetamines)? ❑ Yes ❑ No Which ones? _____ Marital Status (circle one): Single / In a Relationship / Married / Common Law / Divorced / Separated / Widowed Occupation: _____

EMERGENCY CONTACT

Name of local friend or relative:	Relationship to Patient:
Home Phone: ( ) -	Cellular Phone: ( ) -

BY SIGNING THIS FORM YOU ARE ACKNOWLEDGING THAT YOU ARE AWARE OF OUR CLINIC POLICIES AND FEE SCHEDULES.

_____ _____

PATIENT/GUARDIAN SIGNATURE *DATE (DD/MM/YYYY)*

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Office Policy

Privacy and Confidentiality
I understand that the privacy of my information is maintained in strict accordance with the Personal Information Protection and Electronic Documents Act (PIPEDA) as well as the Personal Health Information Protection Act (PHIPA). I acknowledge and authorize this clinic to collect, use and disclose information about me and my dependent children for the following purposes: to provide health care, to advise me of treatment options, to establish and maintain contact with me via telephone/email, to send me newsletters and/or informational mailings, to communicate with my other health care providers (licensed medical practitioners, health care professionals, hospitals, clinics and medical-related facilities), to allow you to follow-up for treatment, care, appointments and billing, to complete claims for insurance purposes, to invoice for goods and services, to allow you to work with my solicitor and/or legal counsel, and to comply generally with the law. I understand that due diligence will be employed and exercised in being discrete about issues conveyed via any mode of communication used to contact me. I understand that some forms of communication may not be secure. I have the right to refuse certain types of communication by notifying the provider or clinic staff in writing.

Extended Health Insurance & OHIP
If applicable, I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided. I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment. I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator. If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Where applicable, I understand that any visits billable to OHIP will be done so by the Family Medicine Physician only. I am responsible to pay in full for any service or treatment that is not covered by OHIP at the time of my visit.

Appointments
I acknowledge and agree that I will keep all appointments as scheduled and should an appointment need to be cancelled/rescheduled, a minimum of 24 hours' notice must be provided otherwise a missed appointment fee will be charged to my account in the amount of $50 + HST for the first infraction and $65 + HST for the second infraction (not covered by insurance plans/OHIP). If appointments are repeatedly missed, I understand that I may be dismissed from this clinic.

If applicable, I further acknowledge and agree that if I arrive late for a massage with the Registered Massage Therapist, I will be responsible for the lost time (i.e. If I am 15 minutes late for a 45 minute massage, the insurance provider will be billed for a 30 minute massage and I will personally be billed a late fee in the amount of $25 + HST to account for the lost time).

Financial
I agree that payment is expected during the clinic appointment and that all treatment rendered is charged directly to me and I am responsible for payment of all goods and services including those that are not reimbursed by third party insurance companies or OHIP. In the unlikely event that it is necessary to discontinue care for any reason, I understand that all outstanding fees become due and payable immediately.

If applicable, I agree and authorize this clinic to bill workers compensation claims, if applicable, directly to the WSIB, however if my claim is denied for any reason whatsoever, I will be responsible for the prompt and immediate payment of my account.

If applicable, I agree and authorize this clinic to bill motor vehicle accident claims, if applicable, through the Health Claims for Auto Insurance (HCAI), however if my claim is denied for any reason whatsoever, I will be responsible for the prompt and immediate payment of my account.

Patient Conduct
I understand that the doctors and therapists at this clinic reserve the right to end my appointment and/or treatment at any time due to inappropriate/suggestive behavior and/or comments.

I HAVE READ, UNDERSTOOD AND AGREED TO THE ABOVE POLICIES AND SUBSEQUENTLY AGREE TO FULLY ABIDE BY THEM.

DATE: _____

PATIENT/GUARDIAN NAME (PRINT): _____

PATIENT/GUARDIAN SIGNATURE: _____ **WITNESS SIGNATURE:** _____