Active Care Chiropractic Clinic

Dr. Ryan L. Barnswell B.Sc. (HON) D.C. C.E.P.

Patient Introduction

Name: _____

Address: _____**City**_____

Province_____ **Postal Code:** _____**Home phone #:** _____

Work #: _____ **Cell #:** _____

Birthdate: (day/month/year)_____ **Gender M/F**

Occupation/Employer: _____ **E-Mail (optional)**_____

Emergency Contact: _____ **Phone #:** _____

Family Doctor: _____ **Last seen:** _____

Family Doctor Phone No. _____**Fax:** _____

Previous Chiropractor: _____ **Last seen:** _____

Recent x-rays: _____ **Date Taken:** _____

Chief complaint: _____ **Onset:** _____

Are you interested in: Pain Relief
(Please circle) **Fixing the Problem**
Wellness or preventative care
All of the above

How did you hear about the office_____
_____

Insurance Information

Extended Health Insurance Provider: _____

Group Name: _____ Certificate/ID #_____

Policy #: _____ Claim #: _____

WSIB Claim #: _____

MVA Claim #:_____

Assignment of benefits available? Y/N

Coordination with another policy? Y/N (if yes, please provide all of the available information as above)

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