Patient Information

Occupational Therapy

Tuxedo Physiotherapy
156-2025 Corydon Avenue
Winnipeg, Manitoba R3P 0N5
(204) 885-1109

Name: _____ _____ _____
Last First Initial

Date of Birth (dd/mm/yy): _____ Identifying Gender: _____

Address (#, Street Name): _____

City/Prov: _____ Postal Code: _____

Cell Phone: (____) _____ Home Phone: (____) _____

Work Phone: (____) _____ Ext: _____ Email Address: _____

Preferred method of contact: Phone ☐ Email ☐ Who referred you?_____

Occupation: _____ Employer: _____

Emergency Contact: _____Phone Number: (____) _____

Relationship to patient: _____

Consent for Assessment and Treatment

Before treatment begins, your therapist will develop and propose a personalized treatment plan based on your health history and initial assessment. The assessment may consist of various tests depending on your condition. You should discuss any questions about you treatment and rehabilitation with your therapist.
Your records may be stored either at a data storage facility digitally or on-site in a filing cabinet.

☐ I agree

Cancellation/No Show Policy

Your appointment time is reserved for you. We require 24 hours' notice for any cancellations. Patients who provide less than 24 hours' notice will be charged a $30 cancellation fee. Patients who do not cancel and do not show up for their appointment will be charged a $45 no show fee.

☐ I am aware of the Cancellation/No Show Policy

Consent for Communication/Release of Information

I authorize the clinic and its associated health professionals to communicate with my doctor, massage therapist, dentist, chiropractor, naturopathic doctor or others deemed as necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree

☐ I do not want my information shared with my other health care practitioners.

Email Communication

Effective July 1, 2014, Canada's new anti-spam legislation requires us to secure your consent so that we can communicate with you electronically.
We would like your permission to send you the following:

☐ Email reminders of upcoming appointments

☐ Instructions and videos regarding prescribed exercises and updates regarding the same.

☐ Notifications regarding upcoming classes/workshops/services.

Name of Patient: _____ Name of Guardian (if applicable): _____

Signature: _____ Date: _____
Patient or Guardian

Medical Information:

Referring Doctor/Professional:_____

Address: _____ Phone Number: (___) _____

Please list any major injuries or surgeries:
_____

Please list current medications: _____

Presence of: ☐ Pacemaker ☐ Artificial Joints ☐ Internal Wires/Pins

Please complete this section if you have a third-party insurer:

Name of Insurer: _____ Contract/Policy #: _____

Name of subscriber (if not yourself): _____

Please complete this section if your treatments are as a result of a Worker's Compensation or Autopac Claim:

WCB/MPIC Claim No.: _____ Adjudicator/Adjustor's Name: _____

If this is an MPIC claim, please specify the location of your claims center: _____

MPIC Injury Claim No.: _____

If this is a WCB claim, please complete the following:

Employer: _____ Address: _____
To expedite the processing of your claim, please ensure that all forms have been completed by your employer and yourself and forwarded to WCB

Click here to email to clinic