Patient Registration Form

Patient Contact Information:

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work: _____ Cell: _____

E-mail: _____ Family Doctor: _____

Date of Birth: _____/_____/_____ BC Care Card #: _____
Month Day Year

Emergency Contact Information:

Relationship: ☐ Spouse/Partner ☐ Parent/Guardian ☐ Other: _____

Name: _____ Phone: _____

I consent to have assessment/treatment information sent to my family doctor: ☐ Yes ☐ No

If this visit is the result of a Motor Vehicle Accident, please provide the following information:

ICBC Claim #: _____ Accident Date: _____

Name of Adjuster: _____ Phone #: _____

How did you hear about us?

☐ Friend: _____ ☐ Online: _____

☐ Doctor: _____ ☐ Other: _____

☐ Health Professional: _____

Please check any and all that apply:

☐ diabetes	☐ recent surgery / fracture	☐ cancer
☐ high blood pressure	☐ rheumatoid arthritis	☐ severe headaches
☐ low blood pressure	☐ osteoporosis	☐ severe dizzy spells
☐ fainting	☐ metal implant	☐ asthma or emphysema
☐ heart disease / atherosclerosis	☐ current pregnancy	☐ difficulty breathing at rest
☐ circulation disorders	☐ infectious disease	☐ allergies: _____
☐ epilepsy	☐ skin condition	☐ other: _____
☐ pacemaker / chest pain		

Is there any reason you could not follow an activity program?

_____

_____

Please list all current medications and supplements including dosages below:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please sign the space below in acknowledgement of your CONSENT to physiotherapy treatment which may involve the therapist asking you questions, observing your movement and posture, measuring your joint range of motion and muscle strength, assessing your nervous and circulatory system. You are free to ask any questions during the assessment and understand that you can stop the assessment at any point.

I authorize Wave Physiotherapy to provide physiotherapy for my condition, which may include but not be limited to manual therapy, manipulations, intramuscular stimulation (IMS) and acupuncture.

I consent to the use of my personal information for billing and account payment purposes and hereby release Wave Physiotherapy and the College of Physical Therapists of British Columbia, its employees and agents, from all claims whatsoever, which may arise because of the release of information.

I understand that if any third party coverage regarding my treatment is refused that I remain responsible for the full payment to Wave Physiotherapy for all outstanding services rendered and/or supplies provided.

SIGNATURE _____

PRINT NAME _____ **DATE** _____

If younger than 18 years of age:

Parent/Guardian's Name: _____ Phone: _____