NEW PATIENT FORM

Thank you for choosing one of our CMCC Clinics

We provide quality chiropractic care. Treatment provided by our interns will be directly supervised by our clinical faculty. Direct and open communication between you and our interns/clinical faculty is very important. Please tell us if you would rather have a male or female intern, require someone other than an intern/clinical faculty to be present during your treatment, you feel uncomfortable with the touch aspects of chiropractic therapy, or you would rather not wear a clinic gown.

PLEASE TELL US ABOUT YOURSELF:

Name: _____
Last Name First Name

Chosen Name: _____ Preferred Salutation/ Pronouns (optional): _____
(If different from above)

Date of Birth: _____
DD/MM/YYYY

Sex (at time of birth): _____ Current gender identity: _____

CONTACT INFORMATION:

Address: _____
Street number Street name

_____
Apartment Number City Postal Code

(_____)_____(_____)_____
Home Phone Cell Phone Email

I consent to allow my clinician/intern to contact me by phone and email Phone: Yes □ No □
Email: Yes □ No □

Emergency Contact: _____ (_____) _____
Name Telephone Number

Date of last Chiropractic Visit: _____

Medical Doctor: _____ (_____) _____
Name Telephone Number

I consent to allow my clinician/intern to contact my medical doctor about my health care.

_____
Patient Signature Witness Signature

How did you hear about us?
Please take the time to let us know how you found out about the Canadian Memorial Chiropractic College:
☐ Magazine ☐ Newspaper ☐ Yellow pages ☐ Community Outreach Program
☐ Signage ☐ Friend or relative ☐ Facebook ☐ Other _____

BILLING INFORMATION:
TYPE OF INJURY:
SECTION 1 WSIB:
Is this a Workplace Safety & Insurance Board Injury? ☐ Yes ☐ No
(If NO, skip to section 2)

WSIB claim number: _____ Date of Accident: _____
DD/MM/YYYY

Employer's Information:
Company Name: _____

Address: _____

_____

Telephone Number: _____Ext._____

TYPE OF INJURY:
SECTION 2 MVA:
Are your injuries related to a motor vehicle case? ☐ Yes ☐ No

Date of Accident: _____ Policy or Claim #: _____
DD/MM/YYYY

Insurers Information:
Company Name: _____

Address: _____

_____

Telephone Number: _____Ext._____

SECTION 3:
Consent: I agree and understand that I am responsible for all charges relating to my visit.

Date: _____ Signature: _____
DD/MM/YYYY

Date: _____ Guardian: _____
DD/MM/YYYY (If patient is under 18 years of age)

As a patient at CMCC, I understand that I am attending a teaching facility and I hereby give my permission to allow observation of my visit by students of CMCC. I also recognize that my care will be supervised by Doctors of Chiropractic and I will receive treatment from chiropractic interns.

Date: _____ Signature: _____
DD/MM/YYYY

Date: _____ Guardian: _____
DD/MM/YYYY (If patient is under 18 years of age)

Please note: All accounts are the responsibility of the patient. Your supplemental or extended health care insurance plan may provide coverage for chiropractic services. We will issue receipt of payment for each payment for this purpose.