CLIENT INSURANCE INFORMATION

Name: _____ Date: _____

Sex: M F Birthday _____Mo. _____Day _____Yr.

Occupation: _____ Employer _____

Address:_____ E-Mail:_____

City: _____ Province _____ Zip Code: _____ Phone _____

Primary Insurance (attach copy of card – front and back):

Insurance Company	
Policy/Certificate #	
Plan #	
Policy Holder Name	
Policy Holder Date of Birth	
Relationship to Client	☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance (attach copy of card – front and back):

Insurance Company	
Policy/Certificate #	
Plan #	
Policy Holder Name	
Policy Holder Date of Birth	
Relationship to Client	☐Self ☐Spouse ☐Child ☐Other

Massage Coverage $ _____ Reflexology Coverage $_____

Acupuncture Coverage $_____ Orthotic Coverage $_____

Chiropractic Coverage $_____ Physiotherapy Coverage $_____

Compressed Stocking $_____ Other Coverage $_____

Reference from Doctor: Yes No Bill limitation for each treatment: $_____

Were you injured in a car accident, or work place accident?

_____

If yes, please fill out below according to injury.

WISB (Workplace Safety and Insurance Board)

Date of Accident:_____ Policy #_____

Adjudicator Name_____ Adjudicator Phone # _____

Claim #_____

Motor Vehicle Accident Information:

Insurance Company: _____ Policy #_____

Adjudicator Name_____ Adjudicator Phone # _____

Claim #_____

Others: