DR.ATOOSA
CHIROPRACTOR
& ACUPUNCTURE PROVIDER

P: (416) 222-7775
E: info@dratoosa.ca

St. Gabriel Medical Centre
650 Sheppard Avenue East
North York, ON M2K 3E4

Patient information (please print)

Full Name: _____ Date of Birth: (mm/dd/yyyy)_____ Gender: M F

Home Address:_____ City: _____ Province: _____ Postal Code:_____

Home Phone:_____ Mobile Phone:_____

Email: _____ Occupation:_____

How did you hear about us? ☐ Family Doctor ☐ Family/Friends ☐ Internet ☐ Advertisment ☐ Walk-In

Emergency Contact: Name: _____ Relationship: _____ Phone:_____

Insurance Information (PRIMARY)

Do you have extended health coverage? ☐ YES ☐ NO Insured's Name: _____

Insured's Employers Name:_____ Insurance Company: _____

Relationship to Insured:_____ Policy Number: _____ Group Number:_____

Insurance Information (SECONDARY)

Insured's Name:_____

Insured's Employers Name:_____ Insurance Company: _____

Relationship to Insured:_____ Policy Number: _____ Group Number:_____

Clinic Policies: (Please read carefully and sign below)

I understand and agree that insurance policies are an arrangement between my insurance carrier and myself. I understand and agree that all services rendered to me are charged directly to me as I am personally responsible for payment. Payment is due when services are rendered. custom-made orthotics will be ordered only when a deposit of 50% is made.

In exchange for providing necessary medical care without making payment at the time when service are rendered (ie. WSIB, motor vehicle accident or extended health benefits), I agree to be responsible for all charges associated with my care, regardless of the insurance company's re-imbursement. By signing below I authorize and give my consent to Dr.Atoosa Chiropractic Clinic to verify my health benefits and dirctly bill my insurance provider for fees due.

I will, within 24 hours of my appointment give notice if I am unable to make my scheduled appointment. After an initial warning there is a charge of $20.00 for a second missed appointment. All subsequent missed appointments will be billed at the regular fee.

I require that my medical records remain private and confidential to everyone except for communications between my treating practitioner and my family doctor.

Patient (Guardian) Signature: _____

Date:_____