ADVANCED SPINE CENTRE
The Road To Recovery

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New Patient Intake Form

To provide you with the best possible care, please complete this form to the best of your ability.

All information is STRICTLY CONFIDENTIAL.

Patient Information

First Name: _____ **Last Name:** _____

DOB (MM/DD/YYYY): _____ **Gender:** ☐ Female ☐ Male ☐ Other

Email: _____

Phone number: _____

Address: _____ **City:**

_____

Province: _____ **Postal Code:**

_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Information

Occupation: _____ **Employer:**

_____

Spouses Information (if applicable)

Spouses Name: _____ **Spouses DOB:** _____

Spouses Employer: _____

Healthcare Information

Family Doctor: _____ Health Card Number: _____

(Required for X-ray and documentation purposes)

How did you hear about us?

☐ Doctor Referral

☐ Friends/Family

☐ Google/Search

☐ Social media

☐ Other: _____

Condition & Treatment Information

Describe your current condition and health goals:

Date of Injury (if applicable): _____ Claim No (if applicable): _____

Medical History

Current medications and relevant medical history:

Family Medical History

Please check if there is a **family history** of the following:

☐ Cancer (Type: _____)

☐ Heart Disease

☐ High Cholesterol / Blood Pressure

☐ Thyroid Disease

☐ Diabetes
☐ Lung Disease
☐ Multiple Sclerosis
☐ Other: _____

Pregnancy Status

☐ I am pregnant
☐ I am not pregnant

Health Conditions

Please check if you **currently have or have had** any of the following:

☐ AIDS/HIV
☐ Anaemia
☐ Arthritis
☐ Asthma
☐ Anorexia
☐ Appendicitis
☐ Bleeding Disorders
☐ Bronchitis
☐ Bowel Disease
☐ Bulimia
☐ Stroke
☐ Tuberculosis
☐ Other: _____

☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Fractures
☐ Glaucoma
☐ Gout
☐ Headaches
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Thyroid Disease
☐ Tumours

☐ High Cholesterol
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Low Back Pain
☐ Lung Disease
☐ Migraines
☐ Neck Pain
☐ Osteoporosis
☐ Pneumonia
☐ Skin Disorders
☐ Ulcers

Consent & Authorization

Electronic Transmission Authorization

I authorize my healthcare provider to submit claims on my behalf to my insurance provider and share relevant information required for processing claims.

Authorization for Release of Health Information

I authorize my healthcare provider to collect, use, and disclose personal health information for diagnosis, treatment, insurance claims, and related medical records.

Assignment of Insurance Benefits

I authorize payment to be made directly to **Advanced Spine Centre Inc.** for services rendered. I agree to provide any insurance reimbursement payments received to the clinic.

Patient Agreement

I have read and understand the above information and confirm it is accurate to the best of my knowledge.

Patient Signature: _____

Date: _____

Parent / Guardian Signature (if applicable): _____

Office Use

Please provide:

☐ Photo ID (Driver's License)
☐ Insurance Card