Alevia®
Health and Wellness Centre™

1251 Huron Street, Unit 111
London, Ontario N5Y 4V1
Tel 519.453.7117 • Fax 519.453.6540

Patient Number: _____

NEW PATIENT INFORMATION

Last Name: _____ Middle Name**:** _____First Name: _____Sex: M/F
Date of Birth: MM/____DD/___YY/___ Address: _____City: _____ Province: ___
Postal Code:_____ Home telephone #: _____Business/Cell #:_____
Occupation/Employer: _____
Address: _____City: _____Province: _____ Postal Code:_____
E-mail Address: _____
Marital Status: _____Spouse or Parents Name: _____
Occupation: _____Employer's Address: _____
City: _____Province: _____ Postal Code: _____
Family Physician: _____ Phone: _____
Emergency Contact Person (Name/Telephone):_____
Payment Options for treatment: Visa MasterCard Cash Interact Other: _____

Insurance Information
Do you have any group, union or personal health and accident insurance? Yes/No
Name of Insurance company: _____ Group #: _____
Named of Insured: _____Relation to patient: _____ Policy: _____
Address: _____City: _____ Province: _____
Phone #: _____Ext:_____ Fax #: _____
Additional Insurance Company: _____ Group #: _____
Name of Insured: _____ Relation to patient: _____ Policy: _____
Address: _____ City: _____Province: _____
Is your condition due to an accident? _____ Illness? _____
Did your accident occur at work? _____ Date of accident: _____
Were you involved in an automobile accident? _____ Date of accident: _____
If this is a work or motor vehicle injury please have all documentation available to our office

Miscellaneous Information
How did you hear about our office? _____
Individual/Advertisement? _____ Name: _____Phone #: _____

Have you had any previous chiropractic care/physiotherapy/acupuncture/massage therapy? (circle all that apply)
Are you currently taking any medication or supplements? _____ Please list: _____
Do you have any drug or other allergies? _____Please list: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ Date: _____

Witness Signature: _____ Date: _____