

Mountainview Health Center
2955 Kingsway, Vancouver, V5R5J4 Tel: 604-435-2285 Fax 604-677-5028
Chiropractic, Exercise Rehab, Kinesiology, Custom Orthotics, Massage Therapy

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: _____ Home Phone () _____

Address: _____ City _____ Province _____ Postal _____

Age: _____ Birth date _____ Sex M F

Email address: _____ Occupation: _____

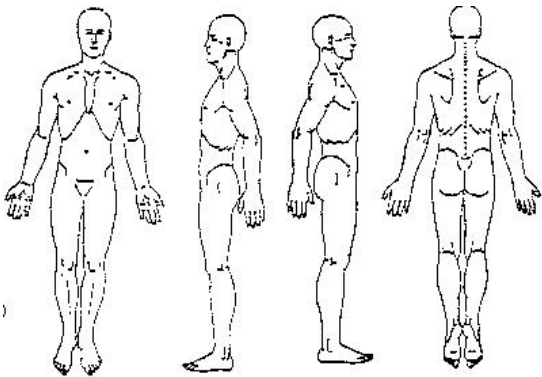
Insurance Information

MSP ICBC WCB CASH 3rd Party

PHN (Care Card) : _____ ICBC, WCB, Extended Health # : _____

Adjuster Name: _____ Adjuster's Number: _____

Referred By: _____ Family Physician: _____



Please Describe and Draw the location of chief complaint

1 _____

2 _____

3 _____

Have you received other treatment for these conditions? Y or N

Family History Cancer Diabetes High Blood Pressure Others _____

Other Health Conditions/Injuries/Concerns _____

I hereby state that the information on all pages of this form is true and correct. I have been informed and understand that in the practice of chiropractic, massage therapy, acupuncture and naturopathic medicine have risks and complications, which will be explained to me by the practitioner.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that any amount authorized by an insurance company or other entity to be paid directly to Mountainview Health Center will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and/or my insurance carrier and that I am personally responsible for payment. If I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless specific arrangements are approved in writing by the practitioner.

Patient/Spouse/Guardian Signature X _____ Date _____