INFORMATION/NEW FILE

ORDRE DES CHIROPRATICIENS DU QUÉBEC

Last name: _____ First name: _____ Date of birth: (M/D/Y) _____

Civil status: Married ☐ Living common-law ☐ Single ☐ Divorced ☐ Widowed ☐ Other ☐ Sex: _____

Address: _____ City: _____ Postal code: _____

Home phone: _____ Cell phone: _____

Office phone: _____ E-mail: _____

What is the best way to reach you? Home phone ☐ Cell phone ☐ Office phone ☐ E-mail ☐

Do you authorize the clinic to contact you by e-mail? Yes ☐ No ☐

Do you authorize the clinic to leave a message at the specified number to confirm an appointment? Yes ☐ No ☐

Occupation: _____ Are you currently on leave from work? Yes ☐ No ☐

Do you have any children? Yes ☐ No ☐ If so, how many? _____

Referred by: Other professional ☐ Name: _____ Clinic: _____

Spouse ☐ Friend ☐ Parent ☐ Co-worker ☐ Name: _____

Advertisement ☐ Website ☐ Yellow Pages ☐ Facebook ☐ Google ☐ Other ☐ : _____

Name of your family physician: _____

Last appointment: _____ Date of last medical examination: _____

Have you ever consulted a chiropractor? Yes ☐ No ☐

Who? _____ When? _____

Are you consulting for a problem related to an occupational accident (CNESST)? Yes ☐ No ☐

Are you consulting for a problem related to a car accident (SAAQ)? Yes ☐ No ☐

Name of representative: _____ File number: _____

Is your treatment covered by a Veterans Program or IVAC? Yes ☐ No ☐

Do you agree to have us reply to requests made by your insurer, Veterans Affairs Canada, IVAC, the CNESST or the SAAQ regarding your treatment dates and the amounts paid for those treatments? Yes ☐ No ☐

Person to contact in case of emergency:

Last name: _____ First name: _____ Telephone number: _____

Relationship: _____

I hereby authorize the chiropractor to conduct the examinations that he or she deems necessary in order to open my file. Some patients may feel soreness or a slight aggravation of symptoms following the examination. Although these symptoms generally do not last long, it is important to mention them to the chiropractor at your next appointment.

Patient's signature or signature of person responsible: _____

Date : _____