mississauga Wellness
INTEGRATIVE MEDICAL REHABILITATION CENTRE

New Patient Information Sheet

Last Name: _____ First Name: _____
Date of Birth: _____ Gender: M / F Occupation: _____
DD MM YEAR
Street Address_____ Unit/Apt. #_____
City _____ Prov._____ Postal Code _____
Tel# (home)_____ Tel# (work)_____
Cell#_____ (Please circle best number)
Email Address_____
Emergency Contact Name: _____ Tel#: _____

Family Doctor: _____
Address: _____ Phone Number: _____

How did you find out about our clinic? (Please circle one of the following)

Internet/Search Flyer Walk-by Church Family/Friend

Pharmacy Dr. Referral Facebook Twitter Other _____

Name of your Insurance Company: _____
What service are you here for today? _____

Please check off any other **Services or Products** we offer that you may be interested in:

- ☐ Physiotherapy
- ☐ Chiropractic
- ☐ Foot Care
- ☐ Naturopathy
- ☐ Massage Therapy
- ☐ Acupuncture
- ☐ Laser Therapy
- ☐ Orthopaedic Shoes
- ☐ Compression Stockings
- ☐ Nutritional Supplements
- ☐ TENS Machine
- ☐ Custom Foot Orthotics

Did you know you can find us online on ***Facebook*** and ***Twitter?***
Or visit us at ***www.mississaugawellness.com.***