GROUP23 SPORTS MEDICINE

ALL SERVICES PATIENT DEMOGRAPHICS

Last Name:	**First Name:**	**Middle Name:**
Street Address:	**City:**	**Province:**
Postal Code:	**Email Address:**	**Date of Birth:** *(dd-mm-yyyy)*
Home Phone:	**Work Phone:**	**Cell Phone:**
Emergency Contact Person:	**Emergency Contact Phone:**	**Emergency Contact Relationship:**

Provincial Health Care Number:	**Sex:**	**Height:** / **Weight:**	**Did your injury occur at work?**	**Did your injury occur as a result of a motor vehicle accident?**
Select your provincial health care provider: ☐ Alberta Health Care ☐ Quebec or international resident ☐ Other Canadian provincial health care	☐ Male ☐ Female ☐ Other, please identify so we can best serve you:		☐ Yes ☐ No	☐ Yes ☐ No

Referring Doctor, if applicable: **Referring Doctor's Clinic:** **Do you consent to having information, such as consult notes, shared with this doctor?** ☐ Yes ☐ No	**Are you currently seeing an allied health provider? If so please list which one(s).** ☐ Physiotherapist: ____________________ ☐ Massage Therapist: ____________________ ☐ Chiropractor: ____________________ ☐ Other: ____________________
Occupation: What is your current job title? If retired or unemployed, what was your previous career? If a student, what grade or program?	**Area(s) of body injured, including side:**
Sports/Activities: What type of sports do you play? At what level? Any physical activities that you enjoy (eg. gardening, hiking etc.)?	**Do you have access to private health insurance?** Coverage for physiotherapy, bracing, prescription medications or health spending? ☐ Yes. Company name: ____________________ ☐ No
Past Medical History: List all medical conditions. ☐ No medical conditions	**Past Surgical History:** List all surgeries with year. ☐ No previous surgeries
List All Current Medications: ☐ No medications	**List All Allergies:** ☐ No allergies

Form continues on next page. Please complete both sides.

Once completed, this information is protected under the Health Information Action (HIA) and the Protection of Personal Information Act (PIPA) and will be retained and disposed of according to the Record Retention & Disposition Schedule, Sections 11010/11015.

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Do you have a family history of muscle or joint conditions?	**Do you smoke/vape/chew tobacco? (Please circle)**	**Do you drink alcohol?**	**Do you use marijuana, CBD, or THC products?**
☐ No ☐ Yes. Please specify (eg. mother: hip osteoarthritis):	☐ No ☐ Yes. How much? ___________ **Did you previously smoke?** ☐ No ☐ Yes. How long? _______years When did you quit? ________	☐ No ☐ Yes. How many drinks per week? _____________	☐ No Yes **Do you take recreational or performance enhancing drugs?** ☐ No ☐ Yes

How did you hear about us?

- ☐ Physician or other health care provider
- ☐ Online search
- ☐ Referral from a current or former patient (let us know who to thank!) ______________________________
- ☐ Other: ______________________________

Initial	Patient Policies – Please Initial box beside policy once you have read it.
	Patient Appointment Confirmations & Reminders: We use automated systems to send patient reminders for most patient appointments. By checking the box below, you consent to Group23 sending notifications via the email address provided on the first page of this form. ☐ I agree to email confirmations, reminders, and notifications *Note: Any contact information shared is regulated by Canada's Anti-Spam Legislation (CASL) and the Health Information Act (HIA)*
	Late Arrivals: Please note that arriving late to appointments that are mid-way through their time slot may not be seen and will be subject to the patient cancellation/no show policy noted below. For all others, the duration of your appointment time will be shortened to allow your provider to meet their next appointment on time, and you will be billed the regular amount for your appointment.
	Patient Cancellation/No Show Policy: Please provide us with at least 24 hours' notice for appointments booked on Tuesday through Friday. For Monday appointments, or those appointments following a statutory holiday, please provide notice by 5:00 p.m. on the previous business day. All missed appointments that do not meet this requirement will be billed a $100.00 fee for physician appointments, or 80% of the cost for the scheduled physiotherapy, massage or health and wellness appointment (not considered a reimbursable charge by your private insurance company).
	Pricing: Prices are subject to change. Please confirm your appointment pricing at each booking.

____
Patient Signature

____
Witness Signature

____
Patient Name (please print)

____
Witness Name (please print)

____
Date

____
Guardian Signature (if patient is under 18 years of age)

____
Guardian Name (if patient is under 18 years of age)

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