Advanced ORTHODYNAMICS

Patient Intake Form

First Name | Middle Initial | Last Name

Name you use | Gender ☐ M ☐ F ☐ X | Title Mr

Birthdate (i.e. YYYY-MM-DD) | Cell Phone

Home Phone | Email

Business Phone | Ext

Contact me by
- ○ Text Cell
- ○ Phone Cell
- ○ Phone Home
- ○ Phone Business
- ○ Email
- ○ iMessage

Street # | Street Name

Street Type | Dir

Suite/Unit | RR# | Lot/Conc

Other Address

City Hamilton | Prov/State ON

Other | Country CAN

P/C (Can) | Zip (US)

Please provide us with the name of your Medical Professional. We may send him/her reports regarding your treatment.

Family Doctor ☐ or
Nurse Practitioner ☐

First Name

Last Name

May we ask how you heard about us?
- ○ Prescribing Physician
- ○ Family Doctor or Nurse Practitioner
- ○ Web Site
- ○ Friends or Family
- ○ Walking By

Do you require documentation for Insurance Purposes? ☐ Yes ☐ No

Please fill out this section if the patient is under the age of 16 or is legally represented by a Spouse, Guardian, Power of Attorney, or Trustee.

I am a: Parent ☐ Spouse ☐ Guardian ☐ Power of Attorney ☐ Trustee ☐ (Select one)

All documentation such as invoices, funding applications etc are to be made out to me/the company as the legal representative of the patient: ☐ Yes ☐ No

All communication such as text messages, emails, and phone calls are to me/the company as the legal representative of the patient: ☐ Yes ☐ No

First Name | Middle Initial | Last Name

Title | Cell Phone

Home Phone | Email

Business Phone | Ext

Contact me by (Select one) ☐ Text Cell ☐ Phone Cell ☐ Phone Home ☐ Phone Business ☐ Email

Address same as patient: ☐ Yes OR please fill in

Street # | Street Name | Street Type | Dir

Suite/Unit | RR# | Lot/Conc | Other Address

City Hamilton | Prov/State ON | Other

Country CAN | P/C or Zip

If the patient is represented by a company, please provide:

Company Name | Contact Name

St# | St Name | St Type | Dir | Ste/Unit

Other Address | City Hamilton | Prov/State ON

Country CAN | P/C or Zip | Phone | Ex