1899 Brock Rd, Pickering ON | L1V 4H7 | (905) 239-0101 | info@parkwayspine.com

Patient Information

Last Name ____________ First Name ____________ Date of Birth (YYYY/MM/DD) ____________

Home Phone ____________ Cell Phone ____________ Gender: Male / Female (please circle one)

Address ____________ City ____________ Postal Code ____________

Email ____________ Occupation ____________ Employer ____________

Marital Status ____________ Spouse Name & Date of Birth (YY/MM/DD) ____________ Spouse's Employer ____________

Family Physician Name & Phone Number ____________ Health Card Number & Version Code ____________

Whom may be thank for referring you to our practice? ____________

We require to keep your credit card information on file. (Please see below)

Card Number ____________ Expiry (MM/YY) ____________ CCV ____________

Extended Health Care Coverage

Insurance Company Name ____________ Policy/Contract Number ____________ Member ID/Certificate Number ____________

Relationship to Cardholder: Self / Spouse / Child (please circle one)

I authorize Parkway Spine & Wellness to submit claims on my behalf to my plan administrator. I consent to my health care provider to collect, use and disclose personal information for the purposes of diagnosing or providing treatment, submitting claims, obtaining medical records on my behalf with the insurer and/or plan administrator, service provider(s) and all parties involved in treatment for the above purposes. ________

I authorize payment to be made directly to Parkway Spine & Wellness for any services and or supplies provided. In the event that payment is not made directly to Parkway Spine & Wellness, I am personally liable for the amount owed to Parkway Spine & Wellness. If I am unable to attend my scheduled appointment I will provide **24 hrs notice** to avoid being charged a missed appointment fee of 100% of the service fee of the appointment. If outstanding payments are not made within 30 days of the service date I authorize Parkway Spine & Wellness to charge the above credit card for any outstanding fees. ________

____________ **Patient or Legal Guardian Signature** ____________ **Date**

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Medical History

Reason for Appointment? ______________________________

Have you had X-Rays, MRI or other special tests? ______________________________

Is this condition related to: Motor Vehicle Accident? ○ Yes ○ No Date of Injury: ____________
Claim #: ____________

Work? ○ Yes ○ No Has your employer been notified? ○ Yes ○ No

Describe your stress level ○ None ○ Mild ○ Moderate ○ High

Are you, or do you plan to become pregnant? ○Yes ○No ○Unknown

Smoker? ○ Yes ○ No How long? __________ years

Please list any previous surgeries: ______________________________
____

List all Mediations (prescription, vitamins, BCP, aspirin,etc): ______________________________
____

Have you ever been diagnosed or suffered from any of the following? (please check)

○ High Blood Pressure
○ Hardening of the Arteries (arteriosclerosis)
○ High Cholesterol
○ Diabetes (Type: ____________)
○ Tuberculosis
○ Cancer (Where: ____________)
○ Heart or blood diseases
○ Osteoporosis
○ Hernia
○ Asthma
○ Thyroid Disease
○ HIV/AIDS
○ Multiple Sclerosis
○ Stroke
○ Visual disturbances (blurring, loss, double)
○ Hearing disturbances (loss, ringing, other noises)
○ Slurred speech or other speech problems
○ Difficulty Swallowing
○Dizziness/Vertigo
○ Loss of Consciousness/Fainting
○ Hepatitis
○ Bowel Condition
○ Skin Disorder
○ Epilepsy
○ Gout
○ Headaches
○ Fractures (Where: ____________)
○ Other: ______________________________

Do any conditions run in your family? ______________________________

I confirm that the information provided is correct and to the best of my knowledge.

______________________________ ______________________________
Patient or Legal Guardian Signature **Date**

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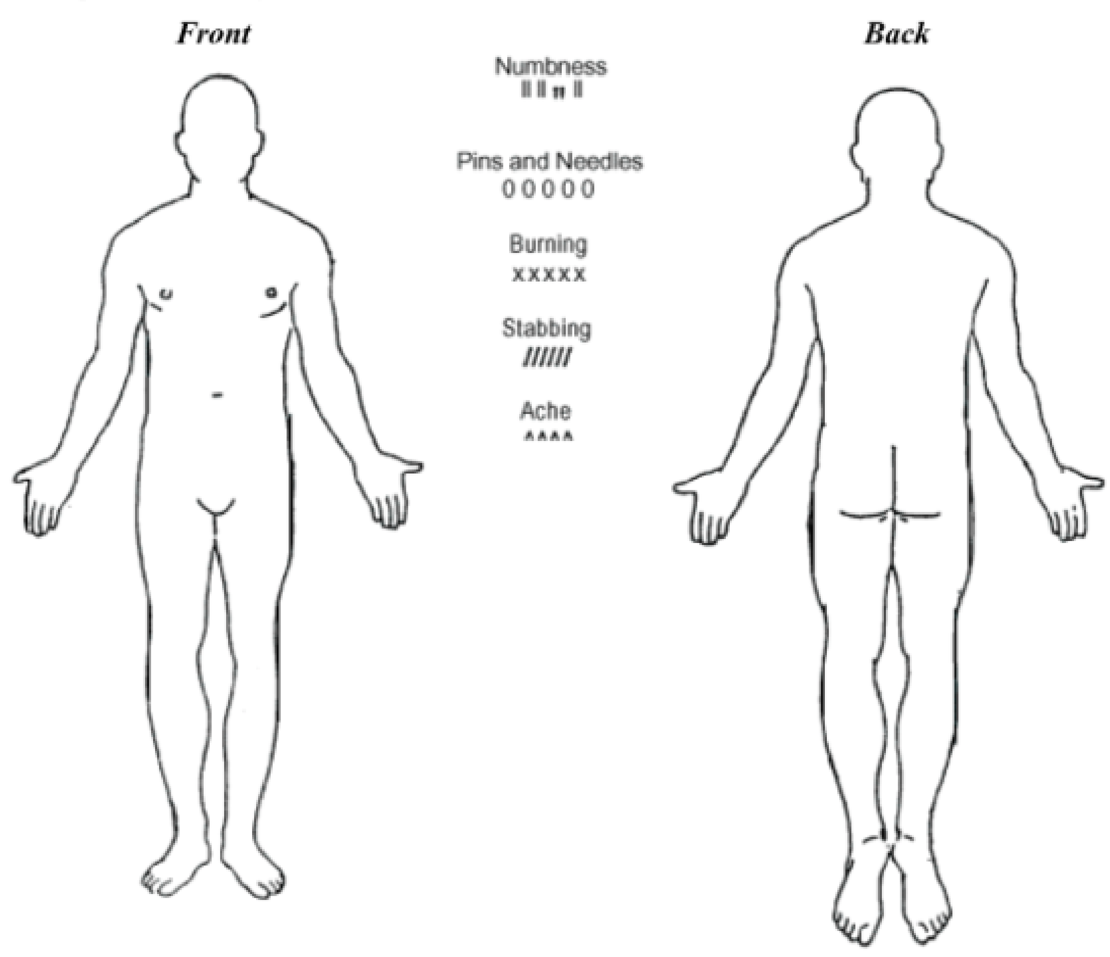
Name: ________________________________ Date: _________________________

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, draw in your face.



Indicate the severity of the pain by selecting a number

○ **0** ○ **1** ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10**

No Pain **Extreme Pain**