ACTIVE REHAB CENTRE

TEL: 416.321.3969
FAX: 416.321.6517
EMAIL: INFO@ARCENTRE.CA
WWW.ARCENTRE.CA
2240 MIDLAND AVE, UNIT 103-104
TORONTO, ONTARIO, M1P 4R8

REGISTRATION FORM

PLEASE HAVE A PIECE OF PHOTO ID, AND YOUR INSURANCE CARD READY & HAND THEM TO THE RECEPTIONIST WHEN YOU ARE FINISHED

PATIENT INFORMATION

*Last name:	*First name:	Middle name:
Title: (Circle one) Mr. Mrs. Ms. Miss Other: _____	*Sex: (Circle one) Male Female Prefer not to answer	*Age: *Birth date: M: D: Year:
Height: (Please note the unit as well – cm, ft, etc.)	Weight: (Please note the unit as well – lbs, kgs, etc.)	Shoe size: (Please note the unit as well – US, EU, etc.)

*Address:

12345 STREET ADDRESS UNIT # CITY PROVINCE POSTAL CODE

*Email:	*Phone no.:	Secondary phone no.:

Preferred Method(s) of Contact: ☐ Email ☐ Phone ☐ Text Message

Family Doctor name:	Family Doctor Phone no.:	Other contact info for Family Doctor:

Chose clinic because/referred to clinic by:

- ☐ Close to Home/Work
- ☐ Family — Who:
- ☐ Friend — Who:
- ☐ Doctor Referral — Who:
- ☐ Sign
- ☐ Newspaper/Flyer — Which one:
- ☐ Internet — How:
- ☐ Other: _____

Other family members seen here:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone no.:	Secondary phone no.:

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INSURANCE INFORMATION

*Are you covered by an insurance plan?:

○ Yes ○ No ○ More than 1

Primary Insurance Details You may skip this section if you selected *No* above.

*Please indicate the insurance company:	*Relationship to holder: (Circle one) ○ Self ○ Spouse ○ Child ○ Other: _____ If the holder is someone other than Self, or your name is different on your card:
Occupation: / Employer:	
*Group/Plan no.:	*Last name: / *First name:
*Certificate/Member no.:	*Birth date: M: D: Year:

Secondary Insurance Details You may skip this section if you have coverage with only one insurance plan.

*Please indicate the insurance company:	*Relationship to holder: (Circle one) ○ Self ○ Spouse ○ Child ○ Other: _____ If the holder is someone other than Self, or your name is different on your card:
Occupation: / Employer:	
*Group/Plan no.:	*Last name: / *First name:
*Certificate/Member no.:	*Birth date: M: D: Year:

AGREEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I authorize Active Rehab Centre or insurance company to release any information required to process my claims. I also authorize Active Rehab Centre to release information regarding my medical condition to my family physician.

_____ _____

Patient/Guardian signature Date