rapson pain clinic

patient insurance information form

please print and fill out the following:

Name:
Date:

If you don't have OHIP, do you have other federal or provincial insurance? YES/NO
If YES, please provide policy information and №:

Provider: Policy No.:

Do you have additional insurance coverage for acupuncture or physiotherapy? YES/NO
If YES, please provide policy information and №:

Company Name: Policy No.:

Is this policy in someone else's name? YES/NO

If YES, please provide full name of policy holder:

Relationship to policy holder:

Is this a WSIB related injury? YES/NO
If YES, please provide policy information and №. If NO, skip this section.

Claim No.: Date of Loss:

Name of Claims Representative:

Rep's Contact Phone No.: Fax No.:

Is this a MVA related injury? YES/NO
If YES, please provide policy information and №. If NO, skip this section.

Company Name: Policy No.:

Claim No.: Date of Accident:

Name of Claims Representative:

Rep's Contact Phone No.: Fax No.: