ADVANCED ORTHOTIC DESIGNS INC. INTAKE FORM

PART 1: **PATIENT** INFORMATION DATE:

FIRST NAME		LAST NAME	
STREET ADDRESS	APT/SUITE NO.		
CITY	PROVINCE	POSTAL CODE	
TEL (HOME)	(WORK)	(CELL)	
EMAIL ADDRESS			
HEALTH CARD NUMBER	DATE OF BIRTH	MALE ❑ FEMALE ❑	
PRIMARY DIAGNOSIS:			
NAME OF INSURANCE COMPANY (for info purposes only):			

I HAVE ACCESSED THE **ONTARIO ASSISTIVE DEVICES PROGRAM (ADP)** BEFORE YES ❑ NO ❑ IF YES, SAME DEVICE? YES ❑ NO ❑ IF SAME DEVICE, HAS IT BEEN OVER 2 YEARS? YES ❑ NO ❑
I AM RECEIVING SOCIAL ASSISTANCE BENEFITS FROM (select one if applicable): ONTARIO WORKS (OW) ❑ ONTARIO DISABILITY SUPPORT PROGRAM (ODSP) ❑ ASSISTANCE TO CHILDREN WITH SEVERE DISABILITIES (ACSD) ❑
I AM ELIGIBLE TO RECEIVE COVERAGE FOR ORTHOTIC DEVICES FROM (select if applicable): WORKPLACE SAFETY & INSURANCE BOARD (WSIB) ❑ CLAIM #: _____ NAME AND PHONE NUMBER OF CASE WORKER: _____ VETERANS AFFAIRS CANADA (VAC) – GROUP A ❑

PART 2: **PARENT** CONTACT INFORMATION (if patient is minor)

MOTHER	FATHER
NAME	NAME
BUS TEL	BUS TEL
CEL TEL	CEL TEL
EMAIL ADDRESS	EMAIL ADDRESS

REFERRING CONTACTS

PHYSICIAN/SURGEON NAME	PHONE NUMBER
PT OR OT NAME	COMPANY NAME/PHONE NUMBER
HOW DID YOU FIND OUT ABOUT US?	