ADVANCED ORTHOTIC DESIGNS INC. PATIENT INFORMATION

PART 1: PATIENT INFORMATION DATE:_____

FIRST NAME	LAST NAME		
STREET ADDRESS		APT/SUITE #	
CITY	PROVINCE	POSTAL CODE	
TEL#(HOME)	(CELL)		
EMAIL ADDRESS			
HEATHCARD NUMBER	VC	DATE OF BIRTH	M ☐ F ☐
PRIMARY DIAGNOSIS:			
NAME OF INSURANCE COMPARY (for info purposes only)			

I have accessed the ONTARIO ASSISTIVE DEVICES PROGRAM (ADP)BEFORE YES ☐ NO ☐
If yes,same device ? YES or No If same device, has it been over 2 years? Yes or 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) ☐

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

MOTHER NAME	FATHER NAME
CELL#	CELL#
BUS.#	BUS#
EMAIL ADDRESS	EMAIL ADDRESS

PART 3: REFERRING CONTACTS

PHYSICIAN/SURGEON NAME	PHONE NUMBER
PT OR OT NAME	COMPANY NAME/NUMBER
How did you find out about us?	