# Cornerstones Wellness Centre Confidential Patient Information

Name: Last _____ First_____ Initial___

Marital Status: Single) ___ Married) ___ Divorced) ___ Widowed) ___
Separated) ___ Common Law) ___

Birth date: (month) _____ (day) _____ (year) _____ Sex: M / F

Address: _____ City _____
Province _____ Postal Code_____

BC Care Card # _____
Family Doctor _____

W.C.B. or I.C.B.C. Claim: _____

Extended Health Insurance:
Policy#_____ ID#_____

Home phone (+area code) _____ _____ _____
Cell / mobile (+area code) _____ _____ _____

- If you would like text reminders, please write down cell phone carrier

Email address _____

☐ I give Cornerstones Wellness & Rehab Centre permission to send me emails regarding upcoming Workshops, programs, classes, etc.

Occupation _____
Employer _____
Work ph (+ area code) _____ Ext _____

Emergency Contact Person: _____
Home ph _____ work ph _____

☐ I am aware that there is a $25.00 no show fee if I miss my appointment with less than 4 hours notice.
☐ I am aware that I will be responsible for payment of this service if WCB or ICBC does not accept my claim. **(If Applicable)**
☐ I give Cornerstones Wellness & Rehab Centre consent to submit to my Extended Health on my behalf. **(If Applicable)**

Referred to this clinic by (family, friend, co-worker, etc.) _____

Cornerstones Wellness Centre is an interdisciplinary clinic and often patients see more than one practitioner. In order for us to provide the best care possible we need your permission so practitioners may discuss your health care needs. Thank you for your assistance. I hereby agree and give permission that, if necessary, my file may be discussed and shared with practitioners at Cornerstones Wellness Centre.

Signature_____ Date: _____