Patient Intake Form

Please print clearly. If you have any questions, please ask our staff. Thank you.

PERSONAL INFORMATION

Legal Name

Chosen/Preferred Name (if applicable) First Name Middle Initial Last Name

Address:

City: Province: Postal Code:

Phone numbers:
Home: Business: Cell:

Email: _____

Yes ☐ No ☐ I consent to receive health and wellness news and information from Lifemark. (You may unsubscribe at anytime).

Appointment Reminder preferences: ☐ Email ☐ Text ☐ Both

Date of Birth ___ / ___ / ___ (Day / Month / Year) Sex/Gender as indicated on Insurance ☐ F ☐ M ☐ X

Gender Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Prefer not to disclose ☐ Other: _____

Date of Injury (D/M/Y) OR gradual onset ☐ Area of Injury:

Employer/School: Occupation:

Health Card #: _____ Version code (ON): _____ Province: _____

For ON/AB: Are you on a Provincially-funded Support Program or qualify as low income? Yes ☐ No ☐
If Yes, please provide name of program, case worker name and phone number:

Extended Health Care Insurance Coverage: ☐ Yes ☐ No For direct billing, please complete below:

Primary Company Name:	Secondary Company Name: (for ON, AB MVA only)
Policy/Plan No:	Policy/Plan No:
Certificate/ID No:	Certificate/ID No:
Policy holder name:	Policy holder name:
Policy holder date of birth (D/M/Y):	Policy holder date of birth (D/M/Y):

Is your injury funded by: ☐ MVA ☐ WCB/WSIB/CNESST ☐ LTD ☐ RCMP ☐ DND ☐ DVA

Claim Number or Member ID: Policy No:
Policy holder Name: Insurance Co. Name:

Employer Name at time of injury: Employer contact & Phone No:

Adjustor/Case Workers' Name: Adjustor Phone No:

For ON/AB/NS MVA claims: Have you completed your Accident benefits package?
(OCF-1/AB1/NS1) Yes ☐ No ☐

Who can we thank for your referral?

Name: Address:

What most influenced your decision to choose Lifemark?

☐ Family Doctor	☐ Returning Patient/Self	☐ Radio/TV	☐ Trade show/Health Fair
☐ Medical Specialist	☐ Rehab Consultant	☐ Signage/Location	☐ Internal referral
☐ Walk-in Clinic	☐ Google Ads	☐ Social Media	☐ Shoppers Drug Mart Pharmacist
☐ Employer	☐ Google listing/Review	☐ Lawyer	☐ Shoppers Drug Mart Health Clinic
☐ Insurance Co.	☐ Internet/Search Engine	☐ Government	☐ Other (Specify): _____
☐ WCB /WSIB/CNESST	☐ Coach/Teacher	☐ Healthcare Professional	
☐ Friend/Relative	☐ Print Advertising	☐ Blue Nose Marathon	

ON Use only:
Photo ID verified: Y/N **HC Expiry:_____** **Staff Initials:_____** **Date:_____**

November 2025

Physicians	
Family Physician:	Phone:
Referring Physician: ☐ Same as Family Physician	Phone:
☐ **Emergency Contact** **AND/OR** ☐ **Guardian (for Patients under the age of 18)**	
Name:	
Relationship to Patient:	Phone: