# Harwood Chiropractic and Massage Centre

**Personal Information** **File #:__________**

Name: ____________________________ ☐M ☐F Birth Date: (m)___(d)___(y)___ Age: ____

Address: ____________________________ City: ____________________Postal Code: ______

Home#: __________________ Work#: ___________________ Cell#: ___________________

Phone# for Messages: ☐ home ☐ work ☐ cell ☐ Email

Email Address: ___________________________

Would you like to receive email for: ☐ our newsletter ☐ our promotions ☐ no thank you

Emergency Contact: __________________________ Phone#: ___________________________

Occupation: _____________________________ Extended Health Coverage: _______________

Who may we thank for referring you to our office?

☐ Clinic Website ☐ Yellow Pages ☐ Friend/Relative __________________________________

☐ Sign ☐ Other: _______________________________________________________________

When were your last x-rays taken? (m)___(d)___(y)___ Of what area? ____________________

Where were the x-rays taken? ______________________________________________________

Do you wear orthotics? ☐ Yes ☐ No Date issued: ____________________

Do you wear compression stockings? ☐ Yes ☐ No Date issued: ____________________

## Patient Communication Authorization

Chiropractors at Harwood Chiropractic Centre and members of its staff may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient or Guardian Signature: _________________________________ Date: __________

## Disclosure of Personal Health Information

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it may be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Patient or Guardian Signature: _______________________________ Date: ____________