Cornerstones Wellness Centre Confidential Patient Information

Date: _______________

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__________________

Home ph (+area code) _____ ______ ________
Cell / mobile (+area code) _____ ______ ________

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 ________________

BC Care Card # ________________________
Family Doctor ___________________________

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

☐ 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 Blue Cross on my behalf. **(If Applicable)**

☐ I am aware that CWC is an Energy Medicine Clinic.

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: ______________________