



WSIB Client Information Sheet

Name: _____

Phone (h): _____

Address: _____

Phone(w): _____

Postal code: _____

Birthdate: _____

Email address: _____

Family physician: _____

Present Employer: _____

Referring physician: _____

Address: _____

Postal Code: _____

Phone #: _____

Please complete the following:

Employer at time of injury: _____

Address: _____

Postal Code: _____

Phone: _____

Fax #: _____

Date of Injury: _____

Area of injury: _____

S.I.N.#: _____

Workplace Safety & Insurance Board Info:

Claim #: _____

Adjudicator's Name: _____

Extension: _____

Nurse Case Mgr.: _____

Extension: _____

Have you been a client here before? Y N

How did you hear about our clinic?

Check off all the ways that you have heard about our clinic:

- another person _____ (name)
- doctor _____ (name)
- newspaper
- phone book
- radio
- arena sign
- Sue's car
- sign outside
- outdoor message board
- website
- other _____

Do you have Extended Health Care

Insurance? Yes _____ No _____

Emergency Contact: _____

Phone #: _____