



PLEASE PRINT

**Name** \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Carecard \_\_\_\_\_

**CONTACT INFORMATION**

Address \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_ Mobile \_\_\_\_\_  
Municipality \_\_\_\_\_ Work \_\_\_\_\_  
City \_\_\_\_\_  
Postal Code \_\_\_\_\_

**\*Would you allow Parkway Physiotherapy and Performance Centre to contact you via email?**

**If YES, provide your email** \_\_\_\_\_

**\*Would you allow Parkway Physiotherapy and Performance Centre to contact your doctors with respect to your medical information?**

**If YES, provide:**

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
Specialist \_\_\_\_\_ Phone \_\_\_\_\_  
Specialist \_\_\_\_\_ Phone \_\_\_\_\_  
Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Parkway Physiotherapy has a 24 hour cancellation policy. If you are unable to attend your appointment, please give at least 24 hours notice, or you will be responsible for paying a \$25.00 non-refundable reservation fee.

I have read and understood the above:

Signature \_\_\_\_\_ Date \_\_\_\_\_