MOSS HEALTHCARE
YOUR HEALTH. OUR PASSION.

Patient Name: _____ _____ _____
Last First Middle

Preferred Name: _____ Gender: Male □ Female □ Other □

Date of Birth (dd/mm/yyyy): _____ Occupation: _____

Home Address: _____ City: _____ Postal Code:_____

Were you injured at work? Is this an ICBC case? If so, please inform reception!

Are you on MSP Premium Assistance/Disability? Yes □ No □

Contact Information:

Home #: _____

E-mail Address: _____

_____

Cell #: _____

Work #: _____

By providing your e-mail address, you agree to receive e-mails from this office, according to the terms and conditions of Canada's Anti-Spam Legislation Law (Section 6)

Emergency Contact-

_____ _____ _____
Name Relationship Phone #

What is your preferred method of appointment reminder? Please note that this is a courtesy reminder, as it is your responsibility to be aware of all of your booked appointments.
Phone Call ☐ E-mail Reminder ☐

Office Policies:

Payment for examination and treatments are due on the day services are rendered. Your treatments or products may be covered, or partially covered, by ICBC, WCB, MSP, or your extended health insurance provider. If, for whatever reason, your coverage is denied, then you are fully responsible for payment of all services rendered.

- Please allow us at least 24 hours' notice if you are unable to keep your appointment.
- If you miss/ no-show your appointment you will be charged the full appointment fee.

All cancellations made within 24 hours of your appointment are subject to a cancellation fee.

I understand and agree to the above policies.

Name: _____ Signature: _____

Date: _____

□ I hereby give consent to share my health history information among the Moss Healthcare professionals (within their respective scopes of practice) for the overall benefit of my health.

Medical History:

Please check all that apply to you below.

Musculoskeletal:
□ Headaches
□ Joint pain
□ Muscle weakness
□ Muscle spasm/cramps
□ Muscle strain
□ Ligament sprain
□ Fracture
□ Dislocation
□ Tendonitis
□ Bursitis
□ Arthritis
□ Osteoporosis
□ Scoliosis
□ Fibromyalgia
□ Whiplash
□ Other: _____

Digestive:
□ Irritable Bowel Syndrome
□ Crohn's Disease
□ Colitis
□ Diverticulosis
□ Ulcers
□ Heartburn/Acid reflux
□ Other: _____

Cardiovascular:
□ High blood pressure
□ Low blood pressure
□ Heart condition
□ Pacemaker
□ Stroke
□ Thrombosis (blood clot)
□ Varicose veins/Phlebitis
□ Swelling
□ Cold hands/feet
□ Dizziness
□ Poor circulation
□ Clotting disorder
□ Other: _____

Respiratory:
□ Asthma
□ Shortness of breath
□ Chronic Cough
□ Other: _____

Family history of serious medical condition-
Cancer: _____
Diabetes: _____
Heart Disease: _____
Other: _____

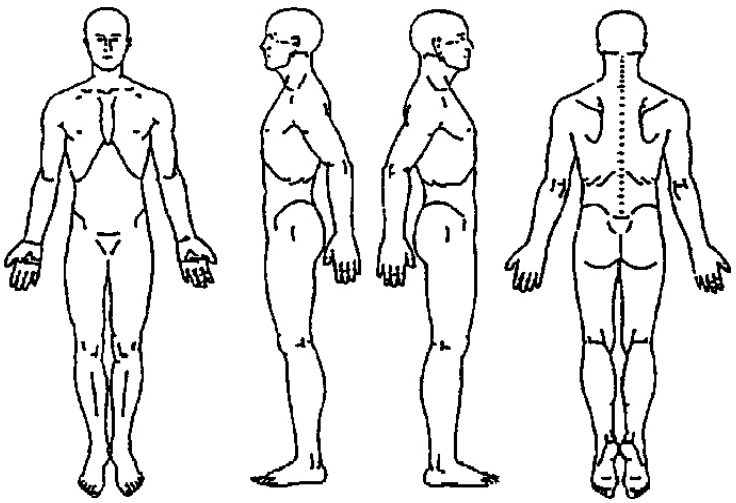
Nervous System:
□ Numbness/ tingling
□ Neuropraxia (nerve compression)
□ Paralysis
□ Cerebral Palsy
□ Seizure disorder
□ Multiple Sclerosis
□ Parkinson's disease
□ Spinal cord injury
□ Head injury
□ Herpes Zoster (shingles)
□ Other: _____

Skin:
□ Rash
□ Athlete's foot
□ Ringworm
□ Acne
□ Eczema
□ Psoriasis
□ Bruise easily
□ Other: _____

Women Only:
□ Pregnancy
□ Menstrual difficulties
□ Ovarian/Uterine disorders
□ Breast issues

Other:
□ Cancer
□ Diabetes
□ Thyroid disease
□ Impaired vision
□ Impaired hearing- including tinnitus
□ Depression
□ Anxiety
□ Fatigue
□ Sleep Difficulties
□ Kidney disease
□ Liver disease
□ Hepatitis
□ HIV
□ Rods/Pins/Plates/Shunts
□ Implants
□ Other: _____

Please mark on the diagram your main areas of complaint:



Family Doctor: _____ Location: _____

Last Visit? _____ For What purpose? _____

Are you presently undergoing treatment for any condition? Yes □ No □ If so, what condition and which practitioners? ___

_____

_____

Please list all of the following-

Major accidents: _____

Major injuries: _____

Surgeries: _____

Medications and what they are prescribed for: _____

Supplements, including vitamins, minerals, and herbs: _____

Allergies: _____

Lifestyle Assessment:

Briefly describe your exercise routine:

_____

_____

How many hours, on average, do you sit daily? _____

Please rate the level of stress in your work life: Low___ Moderate___ High___ Severe___

Please rate the level of stress in your personal life: Low___ Moderate___ High___ Severe___

How many hours do you sleep on an average night? _____

Sleeping position: Back_____ Stomach_____ Right Side_____ Left Side_____ Both Sides_____

How many pillows? _____ Do you feel rested when you wake? _____

Please tell us what you are ultimately hoping to achieve from your experience here:

How did you hear about our office?

☐ Driving by ☐ Internet ☐ Friend (Who? _____) ☐Other: _____

Are you interested in having Dental? YES ☐ NO ☐

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Assignment of Benefits

Please provide the following in order for us to bill your plan directly, if applicable, and to keep your information on file.

Care card (BC PHN) #: _____

Plan Member Name: _____

Plan Member Date of Birth: _____

Insurance Provider: _____

Policy/Group #: _____

ID/Certificate #: _____

Secondary Insurance- if applicable

Plan Member Name: _____

Plan Member Date of Birth: _____

Insurance Provider: _____

Policy/Group #: _____

ID/Certificate #: _____

I understand that the fees listed in this claim and/or future claims may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the service provider for the entire cost associated with this claim and/or future claims.

I hereby assign my benefits payable from this claim and/or future claims to Moss Healthcare and authorize payment directly to them. Moss Healthcare may bill electronically or manually on my behalf.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment, including in the event the benefit payment is made to me, will discharge the insurer/plan administrator of its obligations with respect to that benefit. I understand that this Assignment will apply to all eligible claims submitted by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

I hereby certify that the information provided in connection with this claim is true, accurate and complete. I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information concerning this claim or my health or the health of any insured member of my family as it may relate to this claim to release such information to my insurance provider and to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider. A photocopy of this signed authorization shall be as valid as the original.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

Plan Member's Signature: _____ Date: _____