PATIENT INFORMATION:

LAST NAME: _____FIRST NAME: _____

DOB (mm/dd/yyyy):_____

HOME ADDRESS: _____

CITY:_____ PROVINCE:_____ POSTAL CODE:_____

PRIMARY PHONE #: _____

FAMILY DOCTOR: _____PHONE NUMBER:_____

EMAIL ADDRESS: _____

☐ I allow Be Well to send me emails and I can unsubscribe at any time.

EXTENDED HEALTH BENEFITS INFORMATION:

NAME OF INSURANCE COMPANY: _____

NAME OF POLICY HOLDER: _____

POLICY HOLDER DOB (mm/dd/yyyy): _____

POLICY HOLDERS RELATIONSHIP TO PATIENT: _____

POLICY #: _____

CERTIFICATE OR ID #: _____

NAME OF EMPLOYER: _____

SECONDARY EXTENDED HEALTH BENEFITS INFORMATION (IF APPLICABLE):

NAME OF INSURANCE COMPANY: _____

NAME OF POLICY HOLDER: _____

POLICY HOLDERS DOB (mm/dd/yyyy):_____

POLICY HOLDERS RELATIONSHIP TO PATIENT:_____

POLICY #:_____

ID/CERTIFICATE#:_____

POLICY HOLDER EMPLOYER:_____

PLEASE NOTE WE REQUIRE A 24 HOUR CANCELLATION NOTICE, IF YOU DO NOT NOTIFY US A 50 % FEE WILL BE APPLIED.

Name: _____ Signature: _____