Gleeson Clinic
1304 E. Victoria Ave., Thunder Bay, ON., P7C 1C2
Phone: (807) 623-5531 or (807) 622-2132 Fax: (807) 626-9511

Patient Admittance Form

□ Dr. Dana M. Gleeson, B.Sc., (Hons.), D.C.
□ Dr. Robert P. Beckford, B.Sc., (Hons.), D.C.

Personal History

Last Name: _____ First Name: _____ Initial: ____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone: (____)_____ Work/Cell/Other Telephone: (____)_____

Sex: M( ) F( ) Age: ____ Birth Date: (D/M/Y) _____ No. of Children: ____

Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )

Family/Primary Care Practitioner: _____

Referring Practitioner: (if any) _____

Employer: _____ Occupation:_____

Employer's Address: _____

City: _____ Province: _____ Postal Code: _____

Name and number of emergency contact: _____

Is your injury/condition due to a recent motor vehicle accident or workplace accident? _____

What was the accident date? _____

Do you have coverage for chiropractic/massage services under an extended health plan (either your own/spouse's/parent's?) Yes ( ) No ( )

Have you had previous chiropractic care? _____ If Yes, when? _____

With whom? (Be Specific) _____ Were X-rays taken? _____

How did you hear about our clinic? _____

Patient or Guardian – Please read carefully and sign

Your appointment time is reserved for you. We require 24 hours notice of cancellation or change in all appointments. If sufficient notice is not received, a missed appointment fee may be charged.

Payment is due at the time of service.

Patient Signature: _____ Date Signed: _____

Witness to Signature: _____

☐ I give my consent to receive electronic mail from the Gleeson Clinic

Email address: _____