Gleeson Clinic ***WSIB Intake***

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

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

Personal Information

Last Name: _____ First Name: _____ Initial: _____
Street Address: _____ Home Phone: (___)_____
City: _____ Province: _____ Postal Code: _____
Birth Date: (D/M/Y) _____ Male or Female (please circle your gender)
Health Card: _____ Version Code: _____ Expiry: _____
Social Insurance Number:_____
Employer's Name:_____ Occupation: _____
Employer's Address: _____ Employer's Telephone: _____
Full-Time/or Part-Time (*please circle*) Length of time in current job: _____
Supervisor/Contact Name & Telephone: _____

Date of Accident: (D\M\Y) _____ WSIB CLAIM#: _____
Have you reported this injury to your employer? Yes ( ) No ( )
Has your employer completed a **Form 7**? Yes ( ) No ( )
Have you completed **Form 6** from WSIB? Yes ( ) No ( )

Have you seen any <u>other</u> Doctor/Therapist, or had any other form of treatment for this injury? **<u>If YES</u>, please state when, where, how many visits, diagnosis, Dr's name:** _____
_____
_____
_____

Briefly describe the accident in your own words: _____
_____
_____
_____
_____

State area of injury, signs and symptoms of your injury: _____
_____
_____
_____

Have you had a previous similar injury? _____
Have you been off work with this injury? **<u>If YES</u>, please list dates:** _____
_____
_____

The above information is <u>essential</u> to complete your WSIB Forms. <u>All</u> questions <u>must be</u> answered as accurately as you can, so as not to delay reimbursement.

I understand that by signing this form, I am responsible for all account balances not covered by WSIB, regardless of the reason.

Patient Signature: _____

Witness to Signature Above: _____ Date Signed: _____