# INFORMATION FORM

Last Name _____ Gender ❑ Male ❑ Female

First Name _____ Birthdate ____ / ____ / ____
*Month / day / year*

Address _____ Home Phone _____

City/Town _____ Other Phone _____

Postal _____ Email _____

Employer _____ Occupation _____

Doctor _____ CareCard # _____

WCB/ICBC Claim No. _____ Date of Injury _____

❑ I authorize a registered physical therapist to assess and treat my condition, as they deem appropriate.

❑ I understand that I am responsible for payment of that portion of the treatment fee, which is not paid, directly by my Medical Plan, WCB, ICBC or other insurance.

Signed _____ Date _____
*(parent/guardian, if under 16)*

**Katie Angermeyer, M.Sc, R.P.T.**

**tel.** (604) 885-2969
**fax** (604) 885-2904
**email** dolfit@dccnet.com

**addr** 5711 Mermaid Street,
Unit 102, P.O. Box 2117
Sechelt, BC V0N3A0