

CONFIDENTIAL PATIENT INTRODUCTION

Welcome to our clinic. Please complete the following so that we may help you achieve your optimal level of health! Thank you.

Female
 Male _____ Date _____
First Name Middle Name Last Name BIRTH DATE ____/____/____ AGE _____
D M Y

HOME ADDRESS _____
Street City / Province Postal Code

HOME PHONE _____ BUSINESS PHONE _____ OCCUPATION _____

EMPLOYED BY _____ BUSINESS ADDRESS _____

NAME OF SPOUSE _____ # OF CHILDREN AND AGES _____

CHECK ONE: MARRIED SINGLE WIDOWED DIVORCED SEPARATED

NEAREST RELATIVE OR NEXT OF KIN NOT LIVING WITH YOU _____
Name Relationship

REFERRED BY _____
Address Phone

E- MAIL ADDRESS: _____

IF PATIENT IS UNDER 18 YEARS, NAME AND RELATIONSHIP OF PERSON LEGALLY RESPONSIBLE (Parent, Guardian)

CARECARD NUMBER _____ **FAMILY M.D.** _____

CURRENT HEALTH CONDITION:

1) **WHAT IS YOUR MAIN REASON FOR COMING IN TODAY?** IF YOU HAVE A SPECIFIC CONDITION PLEASE DESCRIBE IN DETAIL. WHEN DID YOU FIRST NOTICE YOUR CONDITION? CAREFULLY DESCRIBE ANY FACTORS WHICH MAY HAVE PLAYED A ROLE IT'S ASSET OR CONTINUATION _____

2) HAS ANYTHING RECENTLY CHANGED OR BECOME WORSE? LIST IN ORDER.

3) ARE YOU BEING HEALED BY ANOTHER PHYSICIAN OR PRACTITIONER PRESENTLY? (ND? MD?) _____

CURRENT MEDICATIONS:

PLEASE LIST ALL OF YOUR PRESCRIPTION MEDICATIONS (SLEEPING PILLS, BIRTH CONTROL PILLS), NON-PRESCRIPTION MEDICATIONS (ASPIRIN, ANTACIDS), VITAMINS, HERBS, ETC.

CURRENT NON PRESCRIPTION /SUPPLEMENTS:

KNOWN ALLERGIES: SUCH AS MEDICATIONS, POLLENS, FOODS: _____

HOSPITALISATIONS, SURGERIES OR SERIOUS INJURIES:

DATE AND DESCRIBE: _____

**OFFICE POLICY REGARDING FEES AND INSURANCE
COVERAGE**

Our fee policy is a reflection of the specialised procedures incorporated in this office and allows us to give what we feel to be the highest quality of naturopathic care.

FEES

Payment for naturopathic services is expected at the time of treatment.

B.C. MEDICAL

B.C. Medical Insurance has removed MSP coverage for naturopathic services. This means that BC residents will no longer receive a partial reimbursement from the government.

EXTENDED MEDICAL

Your medical insurance policy is a contract between you and your insurance company. This office does not collect payment directly from insurance companies.

CANCELLATION AND MISSED APPOINTMENTS

This office requires a minimum of forty-eight (48) hours notice to cancel any appointment. Any missed or rescheduled appointment with insufficient notice will be billed 50% of the appointment cost.

BC RESIDENTS ARE REQUIRED TO SIGN THE AGREEMENT BELOW

I HAVE READ AND FULLY UNDERSTAND THE OFFICE POLICIES AS STATED ABOVE.

Date

PATIENT'S SIGNATURE
parent or guardian