

# PATIENT ADMINISTRATION FORM

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female  
Day/Month/Year

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

# of Children \_\_\_\_\_ Ages of Children \_\_\_\_\_

If patient is a child, give parents first & last names: \_\_\_\_\_

Full Address: \_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work/cell) \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Tel: (\_\_\_\_\_) \_\_\_\_\_

Are you currently under his/her care? \_\_\_\_\_ If 'yes' for what? \_\_\_\_\_

Date of last visit to Medical Doctor: \_\_\_\_\_ Date last physical: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

Have you been treated by a Naturopathic Doctor before? Yes No

If 'yes', by whom? \_\_\_\_\_ When? \_\_\_\_\_

Are you familiar with the services we offer? Yes \_\_\_\_\_ No \_\_\_\_\_

## In Case of Emergency:

Contact: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Full name Relation Telephone

All fees for services and supplements are the responsibility of the patient, payable in full, at time of treatment. Payment may be made in the form of cash, VISA, MASTERCARD, or INTERAC. Please note OHIP does not cover naturopathic services. Many extended health care plans cover some or all naturopathic services, however you will need to check the specifics of your individual plan. We will supply the necessary receipts for submission to your insurance company.

Your appointment is reserved for you. We require 2 business days notice for cancellation of a scheduled appointment. If we do not receive sufficient notice and we cannot fill your appointment time, a fee of \$50.00 will be incurred. This fee covers administration fees and helps to avoid the need to increase our consultation fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# BEACHES NATUROPATHIC

## INFORMED CONSENT

I would like to take this opportunity to welcome you to Beaches Naturopathic Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and nutritional consultations to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. If you are working with a naturopathic doctor a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

### Statement of Acknowledgement

Printed name \_\_\_\_\_

As a patient of this clinic I have read the information and understand that the form of medical care is based on Naturopathic and nutritional care. Beaches Naturopathic Clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs or any nutraceuticals.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS