PYATT HEALTH CENTRE
NATUROPATHIC FAMILY MEDICINE & ONCOLOGY CARE

PATIENT INFORMATION-Child :

Name ____________________ D.O.B _____ / ______/ _____ Age____
Day Month Year

Alberta Health Care # ____________________

PARENT/GUARDIAN INFORMATION:

Address____________________
Street Name & Number

____
City Province Postal Code

Phone # __(_____)_____-__________ Alt Phone # __(_____)_____-__________
Home Work Cell Home Work Cell

Email address:____________________

Emergency contact: ____________________ __ (____) ____ - _______
Phone #

How did you hear about our clinic?____________________

MEDICAL INFORMATION

Family Doctor ____________________ __(____) - ____-________
Name Phone #

Year of last physical exam______ Year of last Vaccination ______ Up to Date___ Not Vaccinated ___

Hospitalizations & surgeries:____________________

____

Prescribed medications:____________________

____

Over the counter medication and supplements:____________________

____

____

Allergies :____________________

Dietary restrictions:____________________

____

HEALTH INFORMATION Patient name:______________________________

Reason for visit:____

Diagnosed conditions:____

____

Current treatments (other than medications & supplements)_______________________________

____

Significant family health history:____

____

Issues at Birth ____

Breastfed: Y / N / for a short time C-section: Y / N Antibiotics given: Y / N

Please rate the following where 1 = very poor and 10 = your ideal state:

Overall health ____ / 10 Energy ____ / 10 Sleep ____ / 10 Stress tolerance ____ /10

REVIEW OF SYSTEMS

Please state any health issues in the following categories that are not already mentioned above, including any significant past issues as well, indicated by a (P) after the condition:

Skin, Hair, Nails:____

Digestive:____

Respiratory:____

Eyes, Ears, Nose, Throat:____

Immune System:____

Weight:____

Urinary:____

Musculoskeletal:____

Mental Emotional:____

Foods ____

Other:____

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If you wish to leave your credit card information here to allow for easier transactions please fill out the following form

Credit Card Information:

Card Type: ____ Master Card ____ Visa

Card Holder Name ____
(As Shown on Card)

Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: __ __ / __ __ C.C.V.: __ __ __
MM YY (On Back Of Card)

I, ____ authorize
Printed Name

Pyatt Health Centre to charge my credit card listed above for agreed upon purchases. I understand that my information will be saved to an encrypted file for future transactions on my account.

X____ Date : _____ / ______/ _____
Signature Day Month Year

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CONSENT TO TREAT & PATIENT RESPONSIBILITY

The Undersigned patient and/or responsible relative or person hereby consents to the following:

I authorize Pyatt Health Centre naturopathic doctors and medical personnel to administer and perform medical examinations, investigations, and medical treatments during the course of my care that are deemed advisable or necessary.

I consent to Pyatt Health Centre contacting me by telephone if needed regarding appointments and follow-up needs.

I am responsible for making my own appointments and notifying Pyatt Health Centre with sufficient notice (one business day prior to my appointment) should I be unable to attend a scheduled appointment. Appointments missed or rescheduled without sufficient notice may carry a financial penalty.

I understand that should I be later than half the length of my appointment I will likely need to reschedule. Though every attempt will be made to accommodate late clients, Pyatt Health Centre is unable to make guarantees in this regard.

I realize that I am responsible for all costs associated with my care at Pyatt Health Centre. This includes, but is not limited to, consultations, treatments, evaluations & labs, supplementation, professional letters/ correspondences and courier & shipping costs. I also know that I will be duly informed by a member of Pyatt Health Centre of any cost prior to my incurring them.

I understand that it is my responsibility to follow-up with my primary care provider at Pyatt Health Centre via a phone or clinic consult every 4 weeks. Inquiries regarding clarification, changes or continuation of my treatment plan will require a follow-up appointment with my primary doctor at Pyatt Health Centre. Email to front desk may be used for general questions or to notify practitioners of adverse reactions or quick up-dates. I understand that my doctor can not diagnose or treat over e-mail.

I will familiarize myself with all instructions or guidance for testing or visits provided by Pyatt Health Centre prior to the scheduled appointment.

Out of respect for the healing environment at Pyatt Health Centre I will refrain from wearing any toiletries and cosmetics that are heavily scented.

____________________________________ ________________________

Patient/ Guardian Signature Date