WELCOME TO ST. JOSEPH'S OSTEOPATHY CLINIC

NEW PATIENT REGISTRATION & CONSENT FORM

Today's date:	Clinic Location: Credit Valley Medical Arts

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ☐ Single / ☐ Mar/ ☐ Div / ☐ Sep / ☐ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: (Mo/Day/Year) / /	Age:	Sex: ❑ M ❑ F

Home street address:	Home phone: ( )	Cell phone: ( )

City:	Province:	Postal Code:	Email:

Occupation:	Employer:	Work phone : ( )

Referred to clinic by (please check one box):

❑ Family	❑ Friend	❑ Doctor	❑ Internet	❑ Other

Name of referring person:

HEALTH QUESTIONNAIRE

(To help insure your well-being while receiving treatment in our clinic, please answer the following confidential questions)

Name of Family Doctor:	Phone:	Have you visited this year? ❑ Yes ❑ No	Have you been seriously ill? ❑ Yes ❑ No

List any medications or prescription drugs you are currently taking:

Please check any conditions that apply to your health or health history:

❑ Heart palpitations	❑ Pacemaker	❑ Congenital heart condition	❑ AIDS or Positive HIV
❑ Heart murmur	❑ Artificial valves	❑ Bruise easily	❑ Blood disorders
❑ Arteriosclerosis	❑ Artificial joints	❑ Heart attack	❑ Sinus problem
❑ Stroke	❑ Recent fractures	❑ Trouble hearing	❑ Thyroid disease
❑ Blood pressure problem	❑ Broken bone(s)	❑ Shortness of breath	❑ Inflammatory rheumatism
❑ Hepatitis/Jaundice	❑ Asthma	❑ Cortisone/steroid therapy	❑ Covid-19 Positive
❑ Liver disease	❑ Allergies	❑ Recent appetite change	❑ Other (note below)
❑ Diabetes	❑ Epilepsy	❑ Pregnant (# months)	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone:

The above information is true to the best of my knowledge. I understand that any portion of fees not covered or paid by my insurance company will be my responsibility. **I will be responsible for late cancellation (less than 24 hours notice) and missed appointment fees.** I further hereby authorize St. Joseph's Osteopathy Clinic Inc. and attending practitioner to administer any examinations and/or treatments that may be deemed necessary.

Patient/Guardian signature Date