NEW PATIENT FORM

TITLE	FIRST NAME(S)	SURNAME	DATE OF BIRTH	AGE

HOME ADDRESS	PHONE NUMBER (HOME)
	PHONE NUMBER (WORK)
	PHONE NUMBER (MOB)
MARITAL STATUS	E-MAIL
CHILDREN (AGES / SEX)	OCCUPATION
DATE OF CONSULTATION	NUMBER OF YEARS IN OCCUPATION

GP NAME/ADDRESS

HAVE YOU RECEIVED ANY TREATMENT OR PRESCRIPTION MEDICINES WITHIN THE LAST YEAR? YES / NO

IF **YES**, PLEASE GIVE DETAILS:

HAVE YOU RECENTLY **LOST / GAINED** (PLEASE CIRCLE) WEIGHT? IF SO... HOW MUCH: _______________LB / KG

SMOKE? **YES / NO**, HOW MUCH ______________/DAY ALCOHOL? **YES / NO**, HOW MUCH?______________/DAY

EXERCISE? **YES / NO**, TYPE? _______________________________ HOW OFTEN? _____________________________

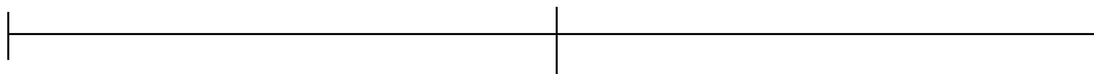
DATE OF LAST MENSTRUAL PERIOD:______________________ DATE OF LAST BREAST SCREENING:______________________

FROM WHOM DID YOU HEAR ABOUT THE CLINIC:

AREA OF MAIN PROBLEM:

PUT A CROSS ON THE LINE BELOW TO INDICATE THE SEVERITY OF YOUR COMPLAINT:

NO PROBLEM **VERY SEVERE PROBLEM**



P.T.O

Do you suffer from? / Have you ever suffered with? (Please circle)			
Backache	Heart attacks/Angina	Blood Pressure	Diabetes
Asthma	Arthritis	Headaches/Migraine	Sinusitis
Cancer	Tiredness	Anxiety /Depression	Stress
Dizziness	Trapped nerves	Digestive Disorders	Whiplash

Consent to write to your GP: **Yes / No**	Do you require a chaperone: **Yes / No**	
Are you covered by health insurance: **Yes / No** (please circle) **If yes**, which one:		
Policy Number:	Group Reference:	Auth No.:

I am aware that X-rays are charged in addition to my new patient consultation fee _________ (initial)

If I cancel or postpone my appointment with less than 24 hours notice, I agree to pay the full fee as if treatment had occurred. Payment of all fees shall be made by me at the time of each visit. If my care is covered by an insurance company, I will provide an authorisation code, policy number and a credit/debit card. In the case of any shortfall, I allow my credit/debit card to be automatically debited the full amount owed. It is advisable to contact the insurance company involved to ascertain details for reimbursement. Failure of an insurance company to reimburse me will not in any way entitle me to a refund from the clinic*. Ownership of all x-rays and records will remain the property of the clinic* even when attending the clinic* through a promotional offer. Records may be copied upon written request in line with gdpr and may incur a charge. Occasionally, it may be necessary to contact me either by post, telephone, text or email regarding appointments or other relevant information**. Please be aware that the practitioner providing your care is responsible for your care. Please contact the practice manager in order to view your personal records or to discuss any problems or queries that may occur.

I have read and understand the terms and conditions above. I confirm that all the information is true to the best of my knowledge and I will inform the clinic if there are any changes *(please sign below)*.

Signed ____ Date ___________________________________

The clinic* refers to the practitioner that is in charge of your care and the surroundings in which treatment is carried out. Should you have any queries, please inform your practitioner that is in charge of your care. This person will be made known to you at the time of initial consultation.

I would like to receive communications from Stanmore Chiropractic Clinic by email ☐

I would like to receive communications from Stanmore Chiropractic Clinic by phone ☐

I would like to receive communications from Stanmore Chiropractic Clinic by text ☐

I would like to receive communications from Stanmore Chiropractic Clinic by post ☐

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