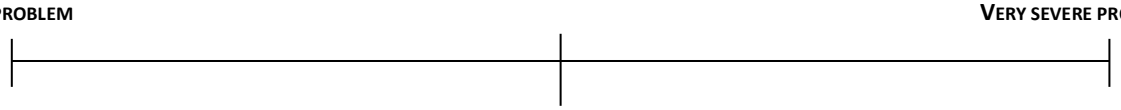
NEW PATIENT FORM

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 (£75/£110) 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. ALL INFORMATION ABOUT YOU IS STORED IN LINE WITH OUR GDPR POLICY**. 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, UNDERSTAND AND AGREE TO 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 MARKETING COMMUNICATIONS FROM STANMORE CHIROPRACTIC CLINIC BY EMAIL ☐

I WOULD LIKE TO RECEIVE MARKETING COMMUNICATIONS FROM STANMORE CHIROPRACTIC CLINIC BY PHONE ☐

I WOULD LIKE TO RECEIVE MARKETING COMMUNICATIONS FROM STANMORE CHIROPRACTIC CLINIC BY TEXT ☐

I WOULD LIKE TO RECEIVE MARKETING COMMUNICATIONS FROM STANMORE CHIROPRACTIC CLINIC BY POST ☐

** IF YOU WISH TO AMEND YOUR SUBSCRIPTION IN LINE WITH OUR GDPR POLICY PLEASE MAKE YOUR PRACTITIONER AWARE OF THIS. YOU CAN UNSUBSCRIBE FROM OUR MAILING DATABASE AT ANY TIME BY FOLLOWING THE APPROPRIATE LINK. THE CLINIC GDPR POLICY IS FREELY AVAILABLE AT STANMORECHIROPRACTIC.COM AND ALSO ON DISPLAY THROUGHOUT THE CLINIC.