SYNERGY
Collaborative Health

Patient Information Form

Please Print

First Name: _____ Last Name: _____

Date of Birth(yyyy/mmm/dd):_____ Gender: □ Male □ Female □ Other

*AHC #: __ __ __ __ __-__ __ __ __

Address:_____

City/Province: _____ Postal Code: _____

Email: _____

By leaving my email address, I agree to emailed appointment reminders in addition to few emails pertaining to information of Synergy Collaborative Health. I can unsubscribe at any time, with the understanding that email reminders will also be cancelled.

Cell Phone #: (___)_____ Home Phone #: (___)_____

Leave messages at: □ Home □ Cell □ Other: (___)_____

Occupation:

_____

Did another physician refer you? Reason for Referral?

_____

Primary Care Physician Contact Information (Referring or Previous):

Physician:_____

Clinic Name: _____ Phone Number: (___)_____

Emergency Contact:

Name:_____

Relationship:_____

Phone Number: (___)_____

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Medical History

Allergies:_____

Medications/Supplements (including herbs and/or vitamins):

_____
_____

- Do you smoke? If so, how much? _____
- Do you take recreational drugs? If so, how much?_____
- Do you drink alcohol? If so, how much? _____

Medical Conditions (Please Circle):

Arthritis
Asthma
Blindness
Cancer
Diabetes
Heart Disease
Hypertension
Kidney Disease
Lung Disease
Mental Illness/Anxiety
Thyroid Disease
Other: _____

Are you Pregnant or trying to become pregnant? Yes / No How Many weeks Gestation? _____

Surgeries?

_____
_____

Accidents,Injuries?_____
_____

Family Medical Conditions: (Write family member beside)

Arthritis: _____
Asthma: _____
Blindness: _____
Cancer: _____
Diabetes: _____
Heart Disease: _____
Hypertension: _____
Kidney Disease: _____
Lung Disease: _____
Mental Illness/Anxiety: _____
Thyroid Disease: _____
Other: _____

Suite 2201, 120 5th Ave, Cochrane, Alberta, T4C 0A4 Phone: 403-981-1999 Fax: 403-981-7676

Cancellation Policy

At **Synergy Collaborative Health**, we enforce a 24 hour cancellation policy. We will need a current credit card on file that we will automatically charge when a patient has missed their appointment or have not given 24 hours' notice. The fee will be dependent on the practitioner and the appointment.

For appointments with Dr. Dave Sinha, a $100.00 charge will be applied to a regular missed appointment and a $250.00 charge for a missed Hypnotherapy appointment.

For appointments with Dr. Holly Sidhu, a $100.00 charge will be applied to a regular missed appointment.

For appointments with Dr. Nyi Than, a $100.00 charge will be applied to a regular missed appointment.

For Ms. Annemieke Aardoom, the **full fee** of $190.00 for a 1 hour session or $270.00 for a 1.5 hour session will be charged if the scheduled time cannot be booked for another client.

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the practitioner's' day that could have been filled by another patient. As such, we require 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a cancellation fee as indicated above.

Thank you for your cooperation.

☐ * I understand that if I do not give a minimum 24 notice prior to cancelling my appointment, or simply do not show up for my appointment, then I will be charged a cancellation fee dependent on the appointment.

Credit Card Number: _____ Type: □ Visa □ MasterCard

Name on Credit Card: _____ Expiry Date: _____ CV: _____

Signature: _____

Please note that this document will be scanned, imported into a Secure Medical EMR and then shredded. No paper copy is kept for security reasons.

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