New Patient Intake 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: (___)______________________________

Preferred Pharmacy: ______________________ Phone: ______________ Fax: ________________

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: (___)_____________________________

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: _________________________________

Cancellation Policy

At Synergy Collaborative Health, we enforce a **24 hour cancellation policy**. It is at the discretion of the physician whether a fee will be charged as outlined below. If you no show for your appointment without a reason more than once, you may not be allowed to book with the physician again.

For regular missed appointments with Dr. Dave Sinha, Dr. Simran Khosa and Dr. Nyi Than a $100 fee may be charged. For a missed Hypnotherapy appointment with Dr. Dave Sinha, MD a $250 fee may be charged.

For Annemieke Aardoom, the full fee of $190 for a 1 hour session or $270 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, may 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 may be charged a cancellation fee. You must pay the feed before you are able to book any further appointments.

Signature: ______________________________ Date: ____________________

Consent to Sharing Information within the Synergy Team

Synergy is a collaborative medical clinic. By working together as healthcare professionals we hope to create an environment of optimal care. We ask your permission to share your medical information, visit notes, reports (laboratory, including diagnostic imaging and specialist consultations) with other practitioners of Synergy as required. The team members may include but are not limited to Dr. Dave Sinha, MD; Dr. Simran Khosa, MD; Dr. Cathryn Zapf, MD; Dr. Deepak Khosla, MD; Dr. Greg Sikorski, ND; Dr. Nyi Than, ND; Annemieke Aardoom, R. Psych; Harpal Rajewal, BAMS, Kulwinder Rajewal, BAMS, Natalie Pateman, OMT; Kandice Wirch, RN, Dixie Baldock, RN; Kiran Sidhu, RN; Sachin Sudra; Sarah Bily.

Signature: ______________________________ Date: ____________________

☐ I consent to sharing personal information and consultation notes relating to my counselling with Annemieke Aardoom and/or Melanie Marsh with the practitioners of Synergy Collaborative Health.

Signature: ______________________________ Date: ____________________

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