Invitation to Health
256 Henry Parry Drive
Wyoming NSW 2250 Ph: 4322 0700

Intake Form - CHILD

Welcome to ITH this is the first step on your path to wellness and we look forward to meeting with you in person.

We have created this comprehensive intake form for you to fill out in advance of coming to see us. We realize it might take some time for you to go through, but this will give you an opportunity to think and remember about your past medical history, about your current medical concerns and reasons for seeking our help. Having all this information on paper will be very helpful when you come in, and we will review this together during your medical or nutritional consultation. We have learned that it is often hard for our patients to remember everything when sitting in front of us!

Patient Information

Title (please circle): Mr. Mrs. Miss Ms. Master Dr Other ….

Name:		Date:
Age:	DOB:	Gender:
Occupation:		
Address Details:		
Suburb:	State:	Postcode:
Home Phone:		
Mobile Phone:	Work Phone:	
Email Address:		
Permission to leave a message on your answering machine or send an SMS: Yes ☐ No ☐		
Emergency Contact Name:	Relationship:	
Emergency Contact Phone Number:		
Next of Kin:	Relationship	
Next of Kin Contact Phone Number:		

Medicare Number:	**Position Number:**	**Medicare Expiry Date:**
DVA Gold/White Number:	DVA Expiry Date:	
Pension/Health Care Card Number:	Card Expiry Date:	Pensioner: Yes / No

Preferred Method of contact for preventative care & early case detection reminders (e.g. immunizations, annual health checks, skin checks and pap smears):
SMS to Mobile Phone: ☐ Message left on answering machine ☐ In writing ☐

Preferred Method of contact to confirm appointments:
SMS to Mobile phone: ☐ Message left on answering machine: ☐

TO HELP THE PRACTICE PROVIDE APPROPRIATE HEALTH CARE, ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?

☐ ABORIGINAL ☐ NEITHER ABORIGINAL OR TORRES STRAIT ISLANDER
☐ TORRES STRAIT ISLANDER ☐ BOTH ABORIGINAL AND TORRES STRAIT ISLANDER

PATIENT CONSENT **(Circle if applicable only)**

I _____**(Parent/Guardian)** understand that the information given to my treating doctor/therapist during my consultation is recorded by the doctor/therapist in my medical file. I give permission for information in my file to be forwarded to other medical persons if it is seen to be necessary for my health. I understand that all information in my file can only be accessed in agreement with my treating doctor on the basis that confidentiality and protection of privacy is assured.

Signed _____ Today's Date:_____

How did you find out about Invitation to Health?

☐ Invitation to Health Facebook Page ☐ Google/other search engine ☐ Magazine/Newspaper

☐ Our Email/Newsletter Communication ☐ Our Website ☐ Word of Mouth ☐ Practitioner Referral

What type of Service are you here for? (Check all that apply)

- ☐ GP Consult
- ☐ Integrative Health Clinic
- ☐ Acupuncture
- ☐ Kinesiology
- ☐ Nutrition
- ☐ Dentist
- ☐ Exercise Physiology
- ☐ Biomedical Consult
- ☐ Traditional Chinese Medicine
- ☐ Osteopathy
- ☐ Psychology
- ☐ Naturopathy
- ☐ Neuro Feedback
- ☐ Other

What brings you to Invitation to Health?

If you had 3 wishes for your visit today, what would they be?

List Medications:

MEDICATION INCLUDING Non-Prescribed Plus Dose *e.g. Coversyl 10mg once a day*	**VITAMIN & MINERAL SUPPLEMENTS**

Allergies – NOT Intolerances	**Prolonged or Regular Use of:**
	☐ OVER THE COUNTER MEDICATIONS
	☐ ACID BLOCKING DRUGS (Losec, Nexium, Pariet)
	☐ STERIODS (Prednisone, Inhalers) in the past
	☐ ANTIBIOTICS
	☐ ANTIDEPRESSANTS

Preventative/Diagnostic Testing: this is vague, suggest saying: please tick if you have done this in the past 1-2 years, or provide the date if you know it.

☐ SKIN CHECK	☐ VACCINATION
☐ BONE DENSITY	☐ COLONOSCOPY
☐ HEMOCCULT STOOL TEST FOR BLOOD	

For Women for this would suggest asking an approximate date: please tick if you have done this in the past 1-2 years, write the approximate date if you know it.	
☐ PAP SMEAR	
☐ MAMMOGRAM	
*** BRING ALL SUPPLEMENTS/MEDICATIONS WITH YOU TO YOUR FIRST APPOINTMENT***	

Past and Current Medical History

Check box if you have been diagnosed with any of the conditions below, either presently or in the past (prior to 6 months)

GASTROINTESTINAL	**CARDIOVASCULAR**	**METABOLIC**
☐ IRRITABLE BOWEL SYNDROME	☐ HEART ATTACK	☐ INSULIN RESISTANCE
☐ INFLAMMATORY BOWEL DISEASE	☐ STROKE	☐ HYPOTHYROIDISM (LOW THYROID)
☐ PEPTIC ULCER	☐ ELEVATED CHOLESTEROL	☐ HYPERTHYROIDISM
☐ GORD (REFLUX)	☐ ARRYTHMIA (IRREGULAR HEART RATE)	☐ POLYCYSTIC OVARIAN SYNDROME
☐ COELIAC DISEASE		☐ BULIMIA
☐ COLONOSCOPY	☐ HIGH BLOOD PRESSURE	☐ ANOREXIA
WHEN	☐ RHEUMATIC FEVER	☐ BINGE EATING DISORDER
☐ OTHER	☐ OTHER	☐ TYPE 1 DIABETES
		☐ TYPE 2 DIABETES
CANCER	**INFLAMMATORY/ AUTOIMMUNE**	☐ OTHER
☐ LUNG CANCER	☐ CHRONIC FATIGUE SYNDROME	
☐ BREAST CANCER	☐ GLANDULAR FEVER	**SKIN DISEASES**
☐ COLON CANCER	☐ HASHIMOTO OR GRAVES	☐ ECZEMA
☐ OVARIAN CANCER	☐ RHEUMATOID ARTHRITIS	☐ PSORIASIS
☐ PROSTATE CANCER	☐ LUPUS/SLE	☐ ACNE
☐ SKIN CANCER	☐ IMMUNE DEFICIENCY DISEASE	☐ MELANOMA
☐ OTHER	☐ FOOD ALLERGIES	☐ SKIN CANCER
	☐ ENVIRONMENT ALLERGIES	☐ OTHER
GENITAL AND URINARY	☐ MULTIPLE CHEMICAL SENSITIVITIES	
☐ KIDNEY STONES	☐ LATEX ALLERGY	**NEUROLOGIC/MOOD**
☐ GOUT	☐ OTHER AUTOIMMUNE	☐ DEPRESSION
☐ INTERSTITIAL CYSTITIS		☐ ANXIETY
☐ FREQUENT URINARY TRACT INFECTIONS	**RESPIRATORY DISEASES**	☐ BIPOLAR DISORDER
	☐ ASTHMA	☐ SCHIZOPHRENIA
☐ FREQUENT YEAST INFECTIONS	☐ CHRONIC SINUSITIS	☐ HEADACHES
☐ ERECTILE DYSFUNCTION	☐ BRONCHITIS	☐ MIGRAINES
☐ SEXUAL DYSFUNCTION	☐ EMPHYSEMA	☐ ADD/ADHD
	☐ PNEUMONIA	☐ AUTISM
MUSCULOSKELETAL OR PAIN	☐ TUBERCULOSIS	☐ MILD COGNITIVE
☐ OSTEOARTHRITIS	☐ SLEEP APNOEA	☐ PARKINSON'S DISEASE
☐ FIBROMYALGIA	☐ OTHER	☐ MULTIPLE SCLEROSIS
☐ CHRONIC PAIN		☐ SEIZURES
☐ OTHER	**PREVIOUS ACCIDENTS OR OPERATIONS**	☐ OTHER
	☐	☐ HEAD INJURIES- WHEN?
	☐	

Further Medical History

YOUR CHILDHOOD HISTORY	FOR WOMEN *OBSTETRIC HISTORY*	MENOPAUSE HISTORY
☐ EAR INFECTIONS	☐ VAGINAL DELIVERIES	☐ HORMONE REPLACEMENT THERAPY
	☐ MISCARRIAGE	
☐ RECURRENT STREP THROAT	☐ ABORTION	☐ CURRENTLY?
☐ STOMACH ACHES	☐ LIVING CHILDREN	☐ YEARS?
☐ OTHER CHILDHOOD ILLNESSES	☐ POST PARTUM DEPRESSION	☐ PAST?
	☐ PRE-ECLAMPSIA	WHEN?
DENTAL HISTORY	☐ GESTATIONAL DIABETES	
☐ SILVER MERCURY FILLINGS	☐ BREAST FEEDING	**LIFESTYLE AND SELF-CARE**
HOW MANY	HOW LONG?	
☐ GOLD FILLINGS	☐ ORAL CONTRACEPTIVE PILL AT ANY TIME?	☐ **Ex-Smoker**
☐ ROOT CANALS		☐ **Currently Smoking: how many per day**
☐ IMPLANTS	WHEN? HOW LONG FOR	
☐ TOOTH OR JAW PAIN	☐ C-SECTION	**SLEEP PATTERNS**
☐ BLEEDING GUMS		☐ HOURS SLEEP EACH NIGHT
☐ GINGIVITIS		☐ DO YOU WAKE OFTEN
		☐ DIFFICULTY GETTING TO SLEEP

Current Symptoms – Please tick if you have any of the following symptoms:

SKIN PROBLEMS	HEAD, EYES & EARS	CARDIOVASCULAR
☐ ACNE	☐ DISTORTED SMELL	☐ CHEST PAIN
☐ ATHLETE'S FOOT	☐ DISTORTED TASTE	☐ BREATHLESNESS
☐ BUMPS BACK OF ARM	☐ BAD BREATH	☐ PALPITATIONS
☐ CELLULITE	☐ EAR FULLNESS	☐ PAIN IN CALVES
☐ DANDRUFF	☐ EAR PAIN	☐ SWOLLEN ANKLES
☐ DARK CIRCLES UNDER EYES	☐ EAR RINGING	☐ VARICOSE VEINS
☐ EARS GET RED	☐ HEARING PROBLEMS	☐ LIGHT HEADEDNESS
	☐ RECURRENT SORE THROAT	☐ FAINTING
	☐ HOARSENESS	**RESPIRATORY**
☐ EASY BRUISING	☐ EYE PAIN/IRRITATION	☐ SNORING
☐ ECZEMA	☐ VISON DISTURBANCE	☐ COUGH
☐ HERPES – GENITAL	☐ SINUS	☐ COUGHING UP BLOOD
☐ COLD SORES	☐ MIRGAINE	☐ HAYFEVER
☐ HIVES	☐ HEADACHE	☐ SINUS FULLNESS
☐ JOCK ITCH	☐ NOISE SENSITIVE	☐ NASAL STUFFINESS
☐ CHANGE IN MOLES	☐ JAW PAIN	☐ NOSE BLEEDS
	☐ ITCHY EARS	BREATHE THRU MOUTH

Current Symptoms continued…

Skin problems continued…	NAILS	Respiratory continued …
☐ OILY SKIN	☐ BITTEN	☐ POST NASAL DRIP
☐ RASH	☐ BRITTLE	☐ SHORTNESS OF BREATH
☐ SENSITIVE TO BITES	☐ FUNGUS	☐ AT REST
☐ SHINGLES	☐ RIDGES	☐ WITH EXERCISE
☐ SKIN ITCHING	☐ THICKENED	
☐ SKIN DRYNESS	☐ WHITE SPOTS/LINES	**ENDOCRINE/IMMUNE**
☐ STRONG BODY ODOUR	☐	☐ COLD HANDS/FEET
ITCHY ANUS OR VAGINA		☐ COLD/HEAT INTOLERANCE
DIGESTION		☐ FATIGUE
☐ BLOATING AFTER EATING	**MUSCLE/BONE**	☐ WEIGHT GAIN
☐ BLOOD IN STOOLS	☐ MUSCLE TWITCHING	☐ GET SICK A LOT
☐ BURPING	☐ MUSCLE PAIN	☐ SWOLLEN LYMPH NODES
☐ CONSTIPATION	☐ JOINT PAN OR SWELLING	☐ HAIR LOSS
☐ ANAL ITCHING	☐ JOINT STIFFNESS	
☐ DIARRHEA	☐ BACK PAIN	**URINARY**
☐ DIFFICULTY SWALLOWING/PAINFUL		☐ HESITANCY
☐ DRY MOUTH	**MOOD NERVES**	☐ FREQUENT UTI
☐ FISSURES	☐ DIFFICULTY CONCENTRATING	☐ PAIN/BURNING
☐ HEARTBURN (REFLUX)	☐ DIFFICULT WITH BALANCE	☐ URGENCY
☐ HAEMORRHOIDS	☐ DIFFICULTY WITH JUDGEMENT	☐ LEAKING
INTOLERANCE TO:	☐ DIFFICULTY WITH MEMORY	☐ BLOOD IN URINE
☐ LACTOSE	☐ DIZZINESS (SPINNING)	☐ FREQUENT URINATION
☐ ALL MILK PRODUCTS	☐ SUICIDAL THOUGHTS	
☐ GLUTEN	☐ DEPRESSION	
☐ CORN	☐ NUMBNESS	
☐ EGGS	☐ PANIC ATTACKS	
☐ FATTY FOODS	☐ ANXIETY	
☐ OTHER	☐ PHOBIAS/FEARS	
DIGESTION	☐ PARANOIA	
☐ YELLOW EYES/SKIN	☐ HELLUCINATIONS	**MALE REPRODUCTIVE**
☐ ABDOMINAL PAIN	☐ SEIZURES	☐ DISCHARGE FROM PENIS
☐ MUCOUS IN STOOLS	☐ TREMOR	☐ EJACULATION PROBLEM
☐ NAUSEA	☐ SLEEPNG PROBLEMS	☐ GENITAL PAIN
☐ STRONG STOOL ODOR	☐ MOTION OR CAR SICKNESS	☐ POOR LIBIDO (LOW SEX DRIVE)
☐ UNDIGESTED FOODS IN STOOLS	☐ FEELING 'OUT OF BODY'	☐ IMPOTENCE
☐ VOMITING	☐	☐ LUMPS IN TESTICLES
☐ UNINTENTIONAL WEIGHT GAIN	☐	☐
☐ FLOATING OR LIGHT-COLOURED STOOL	☐	☐

FEMALE REPRODUCTIVE	PREMENSTRUAL	MENOPAUSE- WHAT AGE:
☐ BREAST CYSTS	☐ BREAST TENDERNESS	☐ HOT FLUSHES
☐ BREAST TENDERNESS	☐ MOODS SWINGS	☐ VAGINAL DRYNESS
☐ OVARIAN CYST	☐ FOOD CRAVING	☐ PAINFUL SEX
☐ POOR LIBIDO (SEX DRIVE)	☐ SLEEP CHANGE	☐ DECREASED LIBIDO
☐ PELVIC PAIN	☐ FATIGUE	☐ WEIGHT GAIN
☐ INFERTILITY	☐ IRRITABILITY	☐ SLEEP DISTURBANCE
☐ VAGINAL DISCHARGE	**MENSTRUAL**	☐ MOOD DISTURBANCE
☐ VAGINAL ITCH	☐ CRAMPS	☐
☐ BLEEDING BETWEEN PERIODS	☐ HEAVY PERIODS	☐
PAINFUL SEXUAL INTERCOURSE	☐ IRREGULAR PERIODS/SPOTTING	☐
	☐ NO PERIODS	☐
	☐ CHANGE IN BOWEL HABIT WITH MENSES	☐

Nutrition and Diet History

Have you made any changes in your eating habits because of your Health ☐ YES ☐ NO.

Describe:

_____

CHECK ALL THAT APPLY PARTIALLY OR FULLY TO YOU:

☐ LOW FAT ☐ LOW CARBOHYDRATES ☐ HIGH PROTEIN ☐ LOW SODIUM ☐ DIABETIC
☐ NO DAIRY ☐ NO WHEAT ☐ GLUTEN RESTRICTED ☐ VEGETARIAN ☐ VEGAN

SPECIFIC PROGRAM FOR WEIGHT LOSS MAINTENANCE TYPE:

_____

☐ OTHER

_____

CHECK ALL THE FACTORS THAT APPLY TO YOUR CURRENT LIFESTYLE AND EATING HABITS:

☐ FAST EATER	☐ ERRACTIC EATING PATTERNS	☐ EAT TOO MUCH
☐ LATE NIGHT EATING	☐ TRAVEL FREQUENTLY	☐ EAT BECAUSE I HAVE TO
☐ EAT TOO LITTLE UNDER STRESS	☐ LOVE TO EAT	☐ EAT IN THE MIDDLE OF THE NIGHT
☐ EAT TOO MUCH UNDER STRESS	☐ HAVE A NEGATIVE RELATIONSHIP WITH FOOD	☐ RELIANCE ON CONVENIENCE ITEMS
☐ DO YOU COOK	☐ DO YOU ADD SALT TO FOOD	☐

STRESS/COPING Check all that apply**:**

☐ I AM SEEING/HAVE SEEN A PSYCHOLOGIST OR COUNSELLOR		
☐ I HAVE AN EXCESSIVE AMOUNT OR STRESS		
DAILY STRESSORS: RATE ON CALE OF 1-10 (10 IS WORST)		
☐ WORK	☐ FAMILY	☐ SOCIAL
☐ FINANCES	☐ HEALTH	☐ OTHER

I PRACTICE MEDITATION OR RELAXATION TECHNIQUE. HOW OFTEN?

Check all that apply**:**

☐ YOGA	☐ MEDITATION	☐ IMAGERY
☐ BREATHING	☐ TAI CHI	☐ PRAYER
☐ ORGANISED EXERCISE	☐ WALKING	☐ OTHER

Readiness to Change

RATE ON A SCALE OF: 5 being (very willing) and 1 (not willing)

In Order to improve your Health. How willing are you to?

Significantly modify your diet?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐
Keep a record of everything you eat each day?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐
Modify your lifestyle?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐
Engage in Regular Exercise?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐
Take several Nutritional supplements each day?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐
Practice a relaxation technique?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐
How confident are you of your ability to organise and follow through on the above health related activities?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐

Exercise - Current Exercise Program

Activity	Type	How often each week	How long

Stretching:
Cardio/Aerobics:
Strength:
Other (Yoga, Pilates etc):
Sports or leisure activity:
Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High list problems that limit activity: _____ Do you feel unusually fatigued after exercise? ☐ Yes ☐ No if yes, please describe: _____ Do you usually sweat when exercising? ☐ Yes ☐ No

Environmental or Other Exposures and Detox Assessment

ADVERSE REACTION TO	**HISTORY OF:**
☐ CAFFEINE	☐ JAUNDICE (TURNING YELLOW)
☐ IRRITABLE WIRED ACHES & PAINS	☐ GILBERT'S SYNDROME OR A LIVER DISORDER
☐ MONOSODIUM GLUTAMATE (MSG)	**EXPLAIN**
☐ ASPARTAME (NUTRASWEET)	
☐ BANANAS GARLIC ONION CHEESE	**EXPOSURE TO HARMFUL CHEMCIALS SUCH AS:**
☐ CITRUS FOODS CHOCOLATE ALCOHOL RED WINE	☐ HERBICIDES
☐ SULPHITE CONTAINING FOODS	☐ INSECTICIDES (FREQUENT VISITS OF EXTERMINATOR
☐ (WINE, DRIED FRUIT, SALAD BARS)	☐ PESTICIDES
☐ PRESERVATIVES (SODIUM BENZOATE)	☐ ORGANIC SOLVENTS
☐ OTHER	☐ HEAVY METALS
	☐ OTHER
YOU ARE AFFECTED BY	
	☐ CHEMICAL NAME/DATE/LENGTH OF EXPOSURE
☐ CIGARETTE SMOKE	
☐ PERFUMES/COLOGNES	
☐ AUTO EXHAUST FUMES	☐ DRY CLEAN YOUR CLOTHES FREQUENTLY
☐ OTHER	☐ LIVED OR WORKED IN A DAMP OR MOULDY ENVIRONMENT OR HAD OTHER MOULD EXPOSURE
	☐ DO YOU HAVE ANY PETS OR FARM ANIMALS
IN YOUR WORK OR HOME ENVIRONMENT ARE YOU	☐ ELECTROMAGNETIC RADIATION
EXPOSED TO:	☐ WORK WITH OIL BASED PAINT - ARTIST OR PAINTER
☐ CHEMICALS	☐ HISTORY OF DRINKING PROBLEM
☐ MOULD	SEE LIFESTYLESECTION FOR DETAILED QUESTIONS

NUTRITION AND DIET

HOW OFTEN DO YOU WEIGH YOURSELF?

☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ RARELY ☐ NEVER

DO YOU AVOID ANY PARTICULAR FOODS? ☐ YES ☐ NO

☐ IF YES, TYPE THE REASON

DO YOU GROCERY SHOP? ☐ YES ☐ NO

IF NO, WHO DOES THE SHOPPING?

DO YOU READ FOOD LABELS? ☐ YES ☐ NO
DO YOU COOK? ☐ YES ☐ NO
IF NO, WHO DOES THE COOKING:
HOW MANY MEALS DO YOU EAT OUT PER WEEK? 0-1 ☐ 1-3 ☐ 3-5 .☐ .>.5 MEALS PER WEEK ☐

Please list below the times you have the following meals, and what you would normally have for each meal

MEAL	TIME	WHAT WOULD YOU NORMALL EAT
Breakfast		
Morning Tea		
Lunch		
Afternoon Tea		
Dinner		
After Dinner		

What would you have for general snacks?

What types of food to you crave?

Are you frequently hungry?

Can you leave 3 to 4 hours between meals without needing to snack? (Not Including overnight)
☐ YES ☐ NO

Birth History:

Delivery:

Vaginal OR LSCS? (please circle)

Please list any birth complications?

Did you or do you have any concerns around milestones being reached?

Has a third party expressed concern in your child's development? (eg Preschool/school/carer)

Fully Immunized: YES NO

Please list any vaccines not received:

Sleep

How many hours sleep does your child have at night? _____
what time does he/she go to bed? _____ wake up? _____
does he/she have issues settling to sleep? _____
does he/she have issues with waking through the night? _____
Do you co sleep with your child often? _____

Exercise – Does your child participate in activities outside of school?

Activity	Type	How often each week

*** PLEASE REMEMBER BRING ALL SUPPLEMENTS/MEDICATIONS WITH YOU TO YOUR FIRST APPOINTMENT***

APPOINTMENT CONFIRMATION & CANCELLATION POLICIES
DEEP HEALTH PROGRAMME

Effective from the 1st December, 2018

Invitation to Health advises we have implemented new policies for Appointment Reminders and Confirmation of Appointments to maximise doctor availability for our patients.

At the time of booking your initial Invitation to Deep Health appointment, your credit card details will be taken and the amount of the first consultation fee held against your card for a period of 10-15 days (depending on your card provider) as a guarantee for your scheduled appointment. At the end of this period, the funds shall be released back to you until the day of your appointment, and your card information will be held and utilised in the event of cancellation or non-arrival fees.

APPOINTMENT CANCELLATION POLICY

All appointment cancellations are required to be made a **minimum of 5 BUSINESS DAYS** prior to your appointment to avoid the **full consultation fee**. ie: If you appointment is scheduled on a Monday, notice to cancel is required by 5pm Monday of the week prior. This includes "No Shows". **The full consult fee will be debited from the credit card stored** and no future appointments shall be made until the cancellation fee has been paid.

SMS REMINDER POLICY

10 days – A reminder text message will be sent to you 10 days prior to your appointment. Please reply to confirm your appointment or call Reception to reschedule. **Failure to reply prior to 2 BUSINESS DAYS in advance of your appointment will result in your appointment being cancelled** and offered to patients on our waiting list. **The full consult fee will be debited from the credit card stored**

24 Hours – A second reminder SMS will be sent 24 hours prior to your appointment as a reminder (no response required).

All patients without mobile phones will be contacted at the same intervals on their landline.

Please sign to acknowledge the above policies.

Signature:

_____Date:_____