PATIENT INFORMATION.

Surname: _____

First Name(s): _____ Title: _____

ID Number: _____ Birth Date: _____

Address: _____

_____ Postal Code: _____

Cell phone number _____

Email: _____

MEDICAL AID INFORMATION / PERSON RESPONSIBLE FOR ACCOUNT.

Name of person responsible for account if not you: _____

ID Number: _____

Email: _____

Medical Aid Name: _____

Medical Aid Number: _____

MEDICAL CONDITIONS.

Health Questionnaire: Please tick applicable box:

Heart Disease	☐	Epilepsy	☐
Insulin Dependent Diabetes (Type 1)	☐	Cancer	☐
Non - Insulin Dependent Diabetes (Type 2)	☐	Asthma	☐
Pacemaker	☐	Exercise Induced Asthma	☐
High Cholesterol	☐	Osteoporosis	☐
High Blood Pressure	☐	Emotional Disorders	☐
Stroke	☐	Musculoskeletal disorders	☐
Deep Vein thrombosis	☐	Other	☐

Please list if you have any pre-existing medical conditions that have not be mentioned above:

Other Medical Condition: _____

_____

Chronic Medication: _____

janelle van onselen

BIOKINETICIST

practice no. 0536148
083 953 6063 . janelle@thebeachclinic.co.za
THE BEACH CLINIC, THE VILLAGE SQUARE
BEACH CRESCENT, HOUT BAY, 7806

PLEASE READ THE FOLLOWING BEFORE SIGNING:

1. I consent to Biokinetic treatment by Janelle van Onselen Biokineticist.
    a. I have disclosed all my medical conditions, medication and any other relevant information.
    b. I consent to Biokineticist treatment and interventions that will be performed on me / my dependant: subject to the Biokineticist performing the relevant safety tests and evaluation, and taking relevant precautions for treatment.
    c. I understand the treatment and potential complications of treatment and or intervention. I have been informed of alternative treatment or intervention.
    d. I indemnify Janelle van Onselen Biokineticist from any liability, damages or whatsoever that I may suffer, and am fully aware that I participate in the activities, and or/use of the equipment inside Janelle van Onselen Biokineticist practice at my own risk.
2. I consent to the release of my diagnosis (ICD 10 coding), medical condition, prognosis, treatment compliance, and treatment program to the following people/institutions for the purpose of reimbursement or settlement of his / her account, and or for referral and reporting purposes.

	Yes	No		Yes	No
Medical Scheme /Funder:			Referring Doctor:		
Employer:			Lawyer:		
School / Coach:			Other medical practitioners:		
Parents:			Spouse:		
Children:			Insurance Company:		
Other:			Comp-solve (Only Injury on Duty):		

3. I _____, the undersigned, accept full financial responsibility for this account until it is settled in full.
    a. This is a cash practice and treatment must be paid at time of consultation, unless otherwise arranged.
    b. Appointments not cancelled 24 hour before the time of appointment will be charged.

I hereby consent that I have read and understand the above.

_____ _____\ _____\ _____

SIGNED: Patient or Guardian of patient <12 years Date

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