Western Herbal Medicine Group

Invigorates lives through natural and alternative medicine (Pty) Ltd

PATIENT REGISTRATION FORM **PATIENT NUMBER:**

Personal Information

Date: D D / M M / Y Y Y Y

Title: **Initials:** **Name:**

Surname:

ID/Passport #.: **Date of Birth:** D D / M M / Y Y Y Y

Gender: Male | Female **Marital Status:** Single | Married | Widowed | Divorced

Email: Mobile:

Address:-

Street:

Postal Code:

Postal:

Postal Code:

Next of Kin Information

Title: **Initials:** **Known As:**

Full Names:

Surname:

Relationship: **Mobile:**

Health Status Information

Length: . M **Weight:** K G **BP:** / **Sugar (HGT):** .

Pregnant: Yes | No **I am nursing/breastfeeding:** Yes | No

Chronic Medication — Please indicate on reverse side.

Organs/body parts removed & operations — Please indicate on reverse side.

Devices and Implants

Pacemaker Yes | No Other Yes | No

I the undersigned, understand that the test/analysis and results are for reference only and not diagnostic conclusions. Medical aids and other health insurance don't cover these services. Our services and products are priced accordingly. Payment is due in full at the time of service and/or product delivery. WHMG is unable to extend a payment plan on its rates. I agree to pay for any missed appointments that were not cancelled or rescheduled at least 24 hours in advance. I am aware of and will pay a late cancellation fee if my appointment is cancelled less than 24 hours from the time of my scheduled appointment. It is agreed that payment will not be delayed or withheld because of any pendency of a claim or discrepancy thereon. I agree to receive postal and electronic communication. I agree that my anonymised clinical information may be shared with to aid research and/or my treatment. I confirm that the information provided is correct.

Patient/Guardian Name in Print **Patient/Guardian Signature** **Date**

: C/o 437 Brits Road & Jan van Riebeeck Street, Pretoria North, Gauteng, South Africa, 0182
/: +27 67 810-3842 : +27 86 636-6116 @: care@westernherbalmedicinegroup.com

Chronic Medication

High blood pressure —Hypertension	Yes	No
Cholesterol	Yes	No
Diabetes	Yes	No
Antidepressants	Yes	No
Cancer — Type	Yes	No
Other	Yes	No
Other	Yes	No

Thyroid Disorder	Yes	No
Blood thinner (Warfarin)	Yes	No
Hormone Replacement Therapy	Yes	No
ADHD/ADD	Yes	No
Other	Yes	No
Other	Yes	No
Other	Yes	No

Organs/body parts removed & operations

	Date
Tonsils	D D / M M / Y Y Y Y
Gallbladder	D D / M M / Y Y Y Y
Pancreas	D D / M M / Y Y Y Y
Spleen	D D / M M / Y Y Y Y
Kidney	D D / M M / Y Y Y Y
Other	D D / M M / Y Y Y Y
Other	D D / M M / Y Y Y Y
Other	D D / M M / Y Y Y Y

Any other health concerns?

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