Poole & Blandford Chiropractic Clinics

Patient Registration Form

Office Use Only	Patient Number:	Date:

PATIENT INFORMATION			
Title:	First Name:	Middle Name:	Last Name:
Date of Birth (dd/mm/yyyy):		Gender (Please circle one): **M F T**	
Address 1:			
Address 2:			
Address 3:			
Town/City:		Home Telephone:	
County:		Work Telephone:	
Postcode:		Mobile:	
Country if not UK:		Email:	
Occupation: If retired, what was your profession:		Medical Insurance: **Yes No**	

GP INFORMATION
Name of GP:
Surgery Name:
Address:
Postcode:

Do you give consent to your GP being kept aware of your progress: **Yes No**
This is not routine and would be discussed with you.

CONSENT TO RELEASE OF INFORMATION (optional)
Sometimes we may believe that sharing your information with other healthcare professionals involved in your care is beneficial to you. I consent to the release of information to my GP/ medical consultant / other healthcare practitioner. Signed: Date: (To be signed by parent/guardian if applicable)

CONSENT TO CLINICAL RESEARCH AND INVESTIGATION (optional)
In order to provide care of the highest quality, staff and doctors of chiropractic often use information from patient health records for research, and/or clinical audit purposes. This will be done anonymously and in confidence. I consent to information from my health record being used for research, and/or clinical audit purposes. Signed: Date: (To be signed by parent/guardian if applicable)

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Informed Consent

Patient:	I.D.:
D.O.B.:	Date:

DATA PROTECTION POLICY (mandatory)

Personal and medical information you give us will be used to provide you with the most effective care, both now and in the future. The information you provide will be shared with the clinicians involved in providing and overseeing your care. Some of it may also be used for administration purposes. Personal information will be anonymized wherever possible and staff only have access to information that is necessary to carry out their duties. All information provided by our patients is treated as confidential and will not be given to any other person(s) or organization(s) without your written consent. You have the right of access to your health records as per the Data Protection Act 1998 (fees apply).

I confirm that I have read the Data Protection Policy and give my consent to the Back In Form Poole and/or Blandford Chiropractic Clinics to maintain records for the purposes outlined within the policy.

Signed: Date:

(To be signed by parent/guardian if applicable)

CONSENT TO EXAMINATION (mandatory)

I hereby give my consent to be examined by the chiropractor and for a record of the examination, and any treatment given, to be kept at the Back In Form Poole or Blandford Chiropractic Clinic.

Signed: Date:

(To be signed by parent/guardian if applicable)

CONSENT TO TREATMENT

I have received a full explanation of my condition; I have had the opportunity to ask questions; I have been advised of treatment options with likely benefits, possible side effects and risks associated with the treatment.

I hereby give my consent to treatment in Back In Form Poole and/or Blandford Chiropractic Clinics.

Signed: Date:

(To be signed by parent/guardian if applicable)