



# Dr. Megan Kimberley, Naturopath.

www.drmorgan.net

Email: drmegankimberley@protonmail.com

Name: \_\_\_\_\_ Age: \_\_\_\_ Date of Birth: \_\_\_\_ (d) \_\_\_\_ (m) \_\_\_\_ (y)

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: (home): \_\_\_\_\_ (office): \_\_\_\_\_

Occupation: \_\_\_\_\_ MSP#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How Did You Hear About Us: \_\_\_\_\_

Health Concerns in Order of Importance for You:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

List Medications and Supplements You Are Currently Taking (Include Dosage):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Health Care Providers (Medical Doctor, Chiropractor...):

\_\_\_\_\_  
\_\_\_\_\_

Please List Any Major Illnesses, Injuries, or Surgery's with Dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any Allergies or Sensitivities?

\_\_\_\_\_  
\_\_\_\_\_



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## **Consent Form**

I \_\_\_\_\_ (Patients name), acknowledge that I am aware naturopathic treatment and conventional medical treatments are not mutually exclusive and I am free to seek or continue medical care from the health practitioners of my choice.

I hereby authorize and consent to naturopathic examination and treatment by Dr. Megan Kimberley, BSc, N.D.

Payment is due the day service is rendered. Extended Benefits may reimburse your fees, when you submit them to your provider. Receipts will be emailed to expediate the process. Do let us know if you need the Underemployed Fee Schedule.

**You will be charged for missed appointments.**

By signing you are acknowledging that you have read and understood the above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_