Lakeside Natural Health Centre,
7 Elmwood Avenue North
Port Credit, Ontario, L5G 3J8
Phone: 905.274.4375 Fax: 905.274.6209

Sonya Myles, RN, BScN, IBCLC
International Board Certified Lactation Consultant

PATIENT INFORMATION:

TODAYS DATE: _____ IS THIS A PRENATAL VISIT: YES_____ NO_____

MOTHERS NAME:_____

PARTNERS NAME:_____

BABY"S NAME:_____

ADDRESS:_____

CITY:_____ PROVINCE:_____ POSTAL CODE:_____

HOME PHONE:_____ OTHER PHONE:_____

MOTHERS BIRTH DATE:_____ AGE:_____

BABYS DUE DATE:_____

BABYS BIRTH DATE:_____AGE:_____

REFERRED BY:_____

EMERGENCY CONTACT PERSON:_____ PHONE:_____

MOTHERS DOCTORS' NAME:_____

BABY"S DOCTORS' NAME:_____

ADDRESS:_____

PHONE NUMBER:_____

EMAIL: _____

(All information is confidential)

I,_____, hereby consent to treatment by Sonya Myles and discussion of my and/or my baby's file with my family doctor or specialist involved in my or my baby's medical case, with my permission .

PLEASE NOTE:
Please sign that you have read and understood this policy and that all the information provided is correct .

_____ _____ _____
Patient Name Signature, or Signature of Legal Guardian Date signed

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CANCELLATION POLICY & PAYMENT OPTIONS

Cancellation Policy

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours advance notice are subjected to a charge of 100% of the fee for the service scheduled. The clinic will retain a record of your credit card only to process missed appointment fees and a receipt will be promptly issued for any missed appointment fees. We appreciate your cooperation with this clinic policy.

Credit Card Information

Card # _____ Exp. _____ 3 Digit Code _____

Payment Options

At Lakeside we are pleased to be able to accept the following method of payments for your convenience:

Cash, Cheque, Debit, Visa and MasterCard

Patient Confirmation

By signing this form you have agreed to the conditions of our cancellation policy and acknowledge our fee schedule and payment options.

I have reviewed the above information and understand that if I do not provide 48 hours notice to cancel my appointments I will be sent an invoice by mail that will be due 15 days from invoiced date.

_____ _____ _____

Patient Name | Signature, or Signature of Legal Guardian | Date signed