**New Patient Information Form**

**First Name: Last Name:**

**Address:**

**Date of birth: Phone Number:**

**Email address:**

**Regular GP:**

**What you like to achieve from seeing a dietitian?**

**Do you currently have any food allergies or intolerances?**

**Do you currently have any medical conditions?**

**Do you take any medications or supplements?**

**How did you hear about MV Nutrition and Dietetics?**

**Consent for Medical Information Collection**

To help provide you with a quality service, MV Nutrition and Dietetics may be required to collect personal information. We may also use this information in correspondence with your health care professionals including doctors, specialists and other health professionals. This is to properly assess your situation and to provide appropriate advice and information.

**Cancellation Policy**

Failure to attend your appointment is unfair to your practitioner and other clients. MV Nutrition and Dietetics requires at least 24 hours notification of all cancellations or reschedules. Failure to do so will result in a fee of 100% of the consultation fee.

By signing this form, I understand:

* My participation is voluntary, I have the right to withdraw my consent.
* I agree to notify the Dietitian of any new health conditions, medications or changes as they arise.
* I have the right to cease consultations at any stage.
* The appointment may be conducted using telehealth via zoom or phone.
* I give my permission for the Dietitian to collect and share my personal/medical information with other health care providers as needed.
* The Accredited Practising Dietitian will take notes during the consultation.
* My referring doctor or health professional will be contacted in reference to my treatments.

My consent relates to:

* A period of care which may involve several consultations via telehealth or face-to-face consultations
* The passing of information in relation to my dietetic treatment to be sent to the nominated email address, which is a secure and safe address that only I have access
* Permission for further specified health professionals to be contacted in reference to my treatments
* I declare that all information provided on this form is true and accurate at the time of signing and that my identify is that stated on this form

**Declaration**

* I agree to notify the dietitian of any new health conditions, medications or changes to the information on this questionnaire as they arise.
* I give my permission for the dietitian to collect and share my personal/medical information with other health care practitioners as needed.
* I acknowledge that my responses on this questionnaire are complete and correct.

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

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

