



# ADVANCED ALLERGY THERAPEUTICS

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone Home \_\_\_\_\_ Work \_\_\_\_\_ Cellular \_\_\_\_\_

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

Age \_\_\_\_\_ DOB \_\_\_\_\_ Occupation \_\_\_\_\_

Who to reach in case of an emergency \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Are you currently receiving health care? Please circle: Y N

If yes, name of physician: \_\_\_\_\_

Condition being treated: \_\_\_\_\_

What are your most important health concerns?

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

Please list tested or suspected allergies and related symptoms:

Foods \_\_\_\_\_

Seasonal \_\_\_\_\_

Drug / other \_\_\_\_\_

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

Daily Dosage \_\_\_\_\_

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)? \_\_\_\_\_

Do you smoke? Please circle: Y N

Please read the New Patient Information form. Sign below when you have finished.

*Yes, I have read and understand the items listed on the New Patient Information form.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(If under the age of 16, must be signed by Parent or Legal Guardian.)

## ADVANCED ALLERGY THERAPEUTICS

### WAIVER AND RELEASE

I \_\_\_\_\_ (the "Undersigned"), hereby consent to treatment at the Akuklinik, 20 Eglinton Avenue East - Suite 402, Toronto, Ontario M4P 1A9

I understand that such procedures are non-invasive.

The Clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results. AAT also cannot guarantee that new allergies will not develop in the future. While AAT can treat most forms of allergies, some cases do not respond to the treatment.

I also understand that the only known risk factor with allergy desensitization, (including medical immunotherapy or AAT) is the possibility of increased sensitivity. I assume all responsibility for unpredictable immune reactions which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention.

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

**No, I do not have any life threatening allergies.**

Yes, I have the following allergies that may cause anaphylaxis:

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I agree to pay the clinic the standard fee for any and all treatments administered.

IN WITNESS THEREOF, the undersigned executed the Agreement as at

the \_\_\_\_\_ day of \_\_\_\_\_ 2011

\_\_\_\_\_  
Signature of Undersigned

\_\_\_\_\_  
Signature of Parent or Legal Guardian