Signature Weight Loss & Wellness

Patient Demographic Information

Name: First_____ Middle_____ Last_____

Nick Name: _____ Date of Birth: _____ Sex: _____ Marital Status: S M D W

Home Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____ Work_____

Driver's License #/State_____ (this is for medication dispensing purposes)

E-Mail Address: _____

Employer: _____ Position: _____

How did you hear about us? _____

Medical History/Medication Information

Are you allergic to any medications? Yes No

If so, please list: _____

Have you ever had or currently have any of the following conditions? (please circle)

Asthma.....Yes No
Blood Clots.....Yes No
Cancer.....Yes No
Diabetes.....Yes No
Fainting Spells.....Yes No
Glaucoma.....Yes No
Heart Attack.....Yes No
Heart Disease.....Yes No
Heart Murmur.....Yes No
High Blood Pressure.....Yes No
High Cholesterol.....Yes No
Seizures.....Yes No
Severe Depression.....Yes No
Stroke.....Yes No
Thyroid Disorder.....Yes No
Other_____

Have you ever had any type of surgery? Yes No

If so, please list: _____

Please list all medications you are currently taking: _____

_____

_____

Are you currently pregnant or breastfeeding? Yes No

Have you ever participated in a weight loss program before? Yes No

If so, when and where? _____

What is your current weight? _____ How tall are you? _____

Automatic Appointment Reminder Information

Our automated appointment reminder system will either call, text, or e-mail you 24hrs prior to your appointment. How would you like us to remind you of your appointment?

Please check only ONE of the following:

_____ Call Reminder at the following phone number _____

_____ Text Reminder at the following phone number _____

_____ E-mail Reminder at the following e-mail address _____

Preferred Language? (please circle one) English Spanish

Emergency Contact Information

We will ONLY contact this person in the case of an emergency.

Name: _____ Relation: _____ Phone: _____

Office Policies

*If you are more than 15 minutes late for your appointment, you may be rescheduled.
*You will be charged a $30.00 fee for any returned checks.
*We DO NOT replace lost or stolen prescriptions or HCG injections once you have left our office.
*Once you have left our office, we are not responsible for the condition or mishandling of your HCG injections.
*Abusing or misusing any prescriptions we prescribe, will result in immediate termination from our practice.

Patient Signature: _____ Date: _____

Knowledge of Receipt of our Notice of Privacy Practices (HIPAA)

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice and how I may obtain access and control this information.

X_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

X_____
PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

X_____
TODAYS DATE