NEW PATIENT DATA

DATE_____ EMAIL_____

NAME_____DATE OF BIRTH_____

ADDRESS_____

APT _____CITY_____STATE_____ZIP CODE_____

HOME PHONE_____WORK PHONE_____CELL PHONE_____

SEX____AGE_____SOCIAL SEC._____DRIVERS LICENSE_____

Do we have your permission to E-mail/mail you information on specials and newsletters? _____

MARITAL STATUS_____NUMBER OF CHILDREN_____AGES_____

OCCUPATION_____EMPLOYER_____

PRIVATE PHYSICIAN_____PHONE #_____

EMERGENCY CONTACT NAME_____PHONE #_____

Your height_____ Weight_____ How long at present weight? _____What is your main reason to lose weight? _____Do you lose weight easily? _____ If NOT, indicate what do you think is the reason_____

Do you usually regain the weight? _____ How soon? _____What do you think your normal weight should be? _____Your goal weight _____Ever weighted that? _____ When? _____What was your highest weight excluding pregnancies? _____ When? _____ What was your lowest adult weight? _____ When? _____What was your weight at age 20? _____Are other family members overweight? _____

If yes who_____

Have you taken prescription diet medications before? _____If yes name(s) _____

_____Year(s) _____Did you lose weight? _____

Side effects_____

How much do you exercise? _____

List all medications you are taking_____

FINANCIAL POLICY: We do not accept or fill insurance forms however we will provide you with a receipt for services rendered. Payments are due at the time services are provided, for your convenience we accept Visa, Master Card, Discover, Care Credit, Cash and Personal Checks with proper identification (NO CHECKS DURING THE FIRST VISIT)

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PATIENT SIGNATURE_____DATE_____