

## Weight Loss and Lipo Centers

Patient Name:				Date:							
Address:				Apt:							
City, State				Zip:							
Email*:											
*By providing your email address you are agreeing to communication via email.											
Home Phone	Primary contact <input type="checkbox"/>	Work Phone	Primary contact <input type="checkbox"/>	Cell Phone	Primary contact <input type="checkbox"/>						
Date of Birth:		Age:		Sex:	Male Female						
SSN:		Marital Status:	S M D	Driver's Lic #:	State						
Employer:			Address:								
Whom may we contact in case of EMERGENCY?											
Name:				Phone:							
<b>How did you hear about us?</b>											
<input type="checkbox"/>	Facebook	<input type="checkbox"/>	Google/ Internet	<input type="checkbox"/>	Newspaper	<input type="checkbox"/>	Magazine	<input type="checkbox"/>	Radio	<input type="checkbox"/>	Billboards
<input type="checkbox"/>	TV / Infomercial	<input type="checkbox"/>	Friend / Patient referral			<input type="checkbox"/>	Other				

### Insurance

Our clinics do not accept payment by insurance. Our receipts are formatted with all information necessary to submit for reimbursements. If you require a Pre Authorization we must receive the forms to complete three business days prior to your appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

### Consent to Treat

I, the undersigned, hereby voluntarily consent and grant permission to HCSC, physician and employees to perform tests, treatment and any procedures as indicated at HCSC for myself or the above named minor, for as long as I am a patient at HCSC.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

### Occupational Hazard

In the event of an injury (i.e. needle stick) to an employee, that exposes any of my bodily fluids, at HCSC premises, I the undersigned, hereby voluntarily consent to give a blood specimen for testing.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

### Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

<b>Name:</b>		<b>DOB:</b>		<b>Today's Date:</b>	
<b>SYMPTOMS:</b> Please circle any of the following symptoms that you <b>have now or have had recently</b> .					
Nervousness / Anxiety	Sweats	Excessive thirst	Blurred vision		
Headache	Loss of weight	Hemorrhoids	Double vision		
Depression	Appetite poor	Indigestion	Earache		
Dizziness	Bowel changes	Nausea	Loss of hearing		
Fainting	Constipation	Stomach pain	Nosebleeds		
Fever	Diarrhea	Vomiting	Ringing in ears		
Forgetfulness	Difficulty swallowing	Ringing in ears	Sinus problems		
Loss of sleep	Excessive hunger	Bleeding gums	Change in moles		
Chest pain	Bruise easily	Wheezing	Rash		
Irregular heart beat	Hives	Persistent cough	Sore that won't heal		
Swelling of ankles	Itching	Coughing blood	Persistent cough		
Shortness of breath	Wheezing	Blod in urine	Painful urination		
Lack of bladder control	Frequent urination	Poor uninary stream			
Pain, weakness &/or numbness in the following:					
Arms	Hands	Feet	Neck		
Back	Feet	Legs	Shoulders		
Men Only:					
Breast Lump	Lump in Testicles	Erection Difficulties	Other: _____		
Women Only:					
Last Mentral Period?	_____	Date of Last Pap Smear?	_____		
Date of Last Mamogram?	_____	Are you Pregnant? _____	# of Children _____		
<b>DIAGNOSES:</b> Please circle if you have been diagnosed or treated for any of the following.					
AIDS	Chemical dependency	High cholesterol	Psychiatric disorders		
Alcoholism	Chicken pox	High Blood Pressure	Rheumatic fever		
Anemia	Diabetes mellitus	HIV positive	Scarlet fever		
Anorexia	Emphysema	Kidney disease	Stroke		
Arthritis	Epilepsy / Seizures	Measles	Suicide attempt		
Asthma	Glaucoma	Migraine headaches	Thyroid problems		
Bleeding disorders	Goiter	Mononucleosis	Tonsillitis		
Breast lump	Gonorrhea	Multiple sclerosis	Tuberculosis		
Bronchitis	Gout	Mumps	Typhoid fever		
Bulimia	Heart disease	Pacemaker	Ulcers – if yes, type		
Cataracts	Hepatitis	Pneumonia	Vaginal infection		
Prostate problem	Polio	Varicose veins	Venereal disease		
Cancer Type: _____		Herpes Type: _____	Hernia: Type: _____		

HOSPITALIZATIONS or SURGERIES			PREGNANCY HISTORY		
Date	Hospital	Reason for hospitalization/surgery	Year of	Boy or Girl	Outcomes / Type of Delivery

**Have you ever had a blood transfusion?** Yes No **If yes, please give approximate dates:**

HEALTH HABITS			OCCUPATIONAL CONCERNS		
Check (√) which substances you use and describe how much use			Check (√) if your work exposes you to the following		
	Caffeine			Stress	
	Tobacco	(packs/day)		Hazardous substances	
	Drugs			Heavy lifting	
	Alcohol	(drinks/week)		Contact with blood or body fluids	
	Other			Other	

**FAMILY HISTORY: Fill in health information about your family.**

Relation	Age	State of Health	Age of Death	Cause of Death	Check (√) if your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Obesity	
Mother					Asthma, Hay fever	
Brothers					Cancer and type	
					Chemical dependency	
					Diabetes	
					Heart disease, Strokes	
Sisters					High blood pressure	
					Elevated cholesterol	
					other	

**WEIGHT HISTORY: (Diet Patients Only)**

Weight Loss Programs	Lowest Weight/Age	Highest Weight/Age	RESULTS COMMENTS
None			
Jenny Craig			
Weight Watchers			
Medical Weight			
Atkins/Low Carb			
Other			

I certify that the above information is correct and complete to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:		Date:	
Reviewed By:		Date:	

