SOLUTIONS WEIGHT LOSS **PATIENT REGISTRATION**

Date: ______________

Last Name: **First Name:**

Gender: **Birth Date:** **Age:** **Height:** **Email Address:**

□ M □ F / /

Address:

City: **State:** **Zip:**

Phone Number: Mobile Number:

( ) ( )

Employer: Occupation: Work number:

How did you hear about us?

□ Clippers Magazine □ Friend or Family □ Regal Cinema at The Loop □ Internet Search □ Drive by/Walk-In

Do you know anyone else in our program? If so, who? Who, if anyone, referred you?

EMERGENCY CONTACT

Name: Relationship: Phone Number: Work Number:

INSURANCE INFORMATION

Medical insurance policies typically do not cover weight management care and related expenses, including laboratory testing, electrocardiograms, prescription medication and related supplements. Your primary diagnosis is overweight or obesity. Payment is due at the time of service. An appropriate receipt of payment will be provided, including a list of charges and descriptions of the office visit for the levels of service provided. The codes used for this purpose may or may not correspond to the codes used by insurance companies. Changes to "codes" will not be made for the use of any insurance company. Insurance companies may reimburse patient for expenses related to weight management; for instance, if weight management is part of the treatment of a comorbid condition. Reimbursement will not be made from the insurance company to the physician. Please note that Solutions Weight Loss will not present a bill to any insurance company for weight management services or related charges. Also, Solutions Weight Loss will not be obligated to complete any form that may be provided by a health insurance company sent to the patient or physician in this regard**.** If you are covered by Medicare you must complete and sign an ABN form prior to participation in this Weight Management Program. **(NOTE: THIS ALSO APPLIES TO ALL AESTHETIC SERVICES AND PRODUCTS)**

PATIENT STATEMENT OF UNDERSTANDING

I have read and fully understand the above information related to insurance and participation in Solutions Weight Loss Program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Patient/Guardian Signature: **Date:**

Printed Name: **If guardian, list relationship to the patient:**

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HEALTH HISTORY

Complete to the best of your knowledge.

Are you under a doctor's care at the present time? □ **Yes** □ **No** If yes, for what?

Is your general state of health (circle one): **Excellent** **Good** **Fair** **Poor**

Alcohol Abuse	□	Drug Abuse	□	**Irregular Pulse**	□
Anemia	□	Eating Disorder	□	Kidney Disease	□
Arthritis	□	Epilepsy	□	Liver Disease	□
Asthma	□	Fainting Spells	□	Lung Disease	□
Bleeding Dz.	□	Fatigue	□	Mental Illness	□
Bloody Stool	□	Food Allergies	□	Migraines	□
Blood Clots	□	UTI	□	Moodiness	□
Cancer	□	Gallbladder dz.	□	Nervousness	□
Chest Pain	□	Glaucoma	□	Obesity	□
Convulsions	□	Headaches	□	Rashes	□
Depression	□	**Heart Disease**	□	Short of Breath	□
Diabetes	□	High Cholesterol	□	Sleep Apnea	□
Diarrhea	□	**Hypertension**	□	Stroke	□
Dizzy Spells	□	Insomnia	□	**Thyroid Disease**	□
Menses irreg.	□	Panic Attacks	□	Anxiety	□
Ovarian Cysts	□	Anorexia	□	Hypoglycemia	□

Medication Allergies		
Medication Name	Reaction	□ I do not have any known allergies

Hospitalizations and Surgeries		
Year	Reason/Diagnosis	Hospital

Current Prescribed Medications, over-the-counter drugs, dietary supplements (inc. vitamins, inhalers, etc)		
Medication Name	**Strength**	**Frequency**

WOMEN ONLY SECTION

Date of last menstruation? / /		
Are you trying for pregnancy?		
Are you sexually active? □ Yes □ No	If yes, what form of birth control are you using?	
Are you breastfeeding?	□ Yes	□ No

Accuracy Agreement	
I hereby agree that the information contained in this Medical history is accurate to the best of my knowledge.	
Signature:	**Date:**

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I hereby agree that the information contained in this Medical history is accurate to the best of my knowledge.

Signature: **Date:**

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