PLEASE PRINT PATIENT INFORMATION FOR WEIGHT CONTROL

SSN_____ Primary Phone (_____)_____

LAST Name (**Print**)_____ Secondary Phone (_____)_____

FIRST Name (**Print)**_____ Date of Birth_____

Street Address (**Print**)_____

City_____ State_____ Zip_____

What work do you do / Position_____ Sex (circle): M F

How did you hear about us? (circle or complete one)

Brochure Direct Mail Drive-by Newspaper Radio Search Engine (Google, etc.)_____ T.V. Walk-in

Yellow Pages Referring Person or Physician Name_____

Email Address (**print carefully**):_____

Which phone number(s) would you like us to call you at? **Circle one or both:** Primary Secondary

For **appointment reminders only**, would you prefer an email or phone call? **Circle one:** Email Phone call Both

Are you **ALLERGIC** to any medicines? NO YES – print them below please

(Please print)_____

Are you taking any **MEDICINES** regularly? NO YES – print them below please

(Please print)_____

IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS, PLEASE CIRCLE THEM.

Epilepsy Seizures Heart Problems Circulation Problems Glaucoma Thyroid Problems Diabetes

Taking MAO medicine Pregnant/Possibly Pregnant/Trying to get Pregnant Currently Breast feeding

Please read this carefully.

A. **We do not take checks.** However, we do accept: cash, Visa, MasterCard, and Discover.
B. Blood work will be done on your first visit and yearly thereafter. In some instances, the doctors may request that your blood work be repeated more frequently than yearly.
C. Return visits should be at least four weeks apart. Your medicine will last four weeks plus two days.
D. You must tell us if you are (or become) pregnant; and you must stop taking the appetite suppressant and all other products from our program. You must see your private doctor.
E. **All fees for services and products are non refundable**. You may exchange appetite suppressants within 30 days, please see posted Exchange Policy for rules and restrictions.
F. Signature below of patient, parent or guardian acknowledges they have read and understand this form. Signatures remain in effect until specifically revoked in writing.

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian Signature (Parent/Guardian if Patient is under the age of 18) **Date**

TURN FORM OVER & COMPLETE

Consent To Procedures and Treatments

Important: Do not sign this form without reading and understanding its contents

During the course of my care and participation in this program, I understand that various types of treatments or procedures (collectively known as procedures) may be necessary. These procedures may be performed by physicians, nurses, medical assistants, or other healthcare persons. While procedures are routinely performed without incident, there may be material risks associated with each one. I understand that it is not possible to list every risk for every procedure, and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures. I also understand that various healthcare persons may have differing opinions as to what constitutes common and/or material risks and alternative procedures.

I understand that I have the right to refuse treatments. I understand this program has the right to not accept me as a patient, or at any time to terminate my participation in this program.

Procedures may include, but are not limited to, the following:

Needle Sticks / Drawing Blood. These are things such as shots, injections, or drawing blood. The material risks associated with this procedure include, but are not limited to, nerve damage, muscle pain, radiating pain, pain at or near the injection site, infection, bruising, bleeding, scarring, loss of limb function, paralysis, allergic reaction, or death. The alternative to needle sticks (shots or injections) or drawing blood, is refusal of treatment.

Physical Exam. No material risk is associated with this procedure. The alternative is refusal of treatment.

Administration Of Medications. Medications may be given orally, topically, or by injection. Material risks associated with these types of procedures include, but are not limited to, pain, puncture, infection, allergic reaction, skin rashes, bodily changes, brain changes, or death. One alternative is administration by a different method (if available in this office), and the other alternative is refusal of treatment.

I understand that:

- The practice of medicine is not an exact science, and that no guarantees or assurances have been made to me concerning the outcome and/or result of my being on this program.
- The healthcare persons participating in my care will rely on my documented medical history, as well as other information obtained from me, in determining my participation in this program.
- I agree to provide accurate and complete information about my medical history and conditions.

By signing this form:

- Unless refused by me, I agree to healthcare persons performing procedures on me as they deem reasonably necessary or desirable, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained.
- I acknowledge that I have read this form and that all my questions about it have been answered to my satisfaction
- I agree that this form gives me, in general terms, the nature of procedures, the material risks of procedures, and practical alternatives to procedures.
- I agree that if I have any questions or concerns regarding these procedures, or any other things about this program, I will ask the healthcare persons to provide me with additional information.
- I indicate I have read this paper, I agree to follow the weight control program, and I authorize Dr. Smith, the physicians of the Get-Thin program, and the staff of the Get-Thin program to provide me with medical care as determined by Dr. Smith and the other physicians.

This consent will stay in effect until specifically revoked in writing.

_____ _____

Patient Name (PRINT) **Social Security Number**

_____ _____

SIGNATURE - Patient or Parent/Guardian **Date**