WEIGHT LOSS PATIENT APPLICATION FORM

Dear Patient

The following personal information is required from you for our records to establish a permanent medical history file in our office. You can be assured that this information will be kept confidential and be transmitted to others only upon your request. Our Primary concern is to protect your privacy, maintain a minimum history file, to protect your health and be able to contact you in the event of an emergency.

Thank You

PLEASE PRINT CLEARLY

SSN: _____ - _____ - _____ DATE OF BIRTH:_____AGE:____ SEX: □F □M

NAME:_____ EMAIL:_____

ADDRESS:_____ CITY: _____ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____ CITY: _____ZIP:_____

WORK PHONE:_____ EXT:_____

IN CASE OF EMERGENCY CONTACT:_____ PHONE: _____

PATIENT STATEMENT & SIGNATURE

I, the undersigned, agree to make a sincere effort to adhere to the diet requirements specified by the clinic and understand that I will be taking medication solely for the purpose of losing weight. I further understand that if I experience adverse side effects, or I am pregnant or think I am pregnant, I am to **stop** the medication and call the clinic doctor.

Signed:_____ Today's Date: _____

STATEMENT OF NON-PREGNANCY

I,_____ hereby declare and state that to the best of my knowledge I am **NOT** pregnant. My last menstrual cycle was_____ to _____. If, during the course of my treatment I have reason to believe that I have become pregnant, I will immediately notify the clinic doctor.

Signature:_____ Date:_____

Witness:_____ Date:_____

Please fill out medical history on next page