PATIENT INFORMATION

Name:____ Date of Birth:______________

❒ Male ❒ Female **Email Address:** ____

Address____
(Street) (City) (State) (Zip)

Mobile Phone: ____________________Home Phone: ____________________Work Phone:__________________

Place of Employment____ Occupation___________________________

How did you hear about Physician's Plan? ❒ Internet ❒ Television ❒ Facebook/Social Media ❒ Previous Patient

❒ Friend/Family Member ____________________________ ❒ Other ___________________________________

HEALTH HISTORY

How would you rate your overall health?

❒ Excellent ❒ Good ❒ Fair ❒ Poor

Are you currently taking any medications (include prescription, OTC and vitamins or supplements)? List name and dose:

____

____

____

____

____

____

Have you ever taken any prescription diet medication? ❒ No

❒ Yes: ________________________________

Have you ever taken any over the counter (OTC) diet medications before? ❒ No ❒ Yes:_______________

Do you have any allergies? ❒ No ❒ Yes:_______________

____

Have you been seriously ill in the past 10 years? ❒No ❒Yes:

____

Do you have any chronic health conditions? ❒ No ❒ Yes:

____

Do you have a Primary Care Physician? ❒ No ❒ Yes

Provider Name: ____________________________

Date of last routine physical? ____________________

Have they ever advised you to lose weight? ❒ Yes ❒ No

Do they know you are a patient here? ❒ Yes ❒ No

May we contact and/or update them? ❒ Yes ❒ No

Do you use any tobacco products? ❒No ❒ Yes, how much and for how long?______________________________

Do you drink alcohol? ❒No ❒ Yes, type & drinks per week?

____

Do you have any health concerns/complications that contribute or are affected by your weight?

❒ Diabetes ❒ Arthritis ❒ High Cholesterol

❒ Heart Disease ❒ Thyroid Problems ❒ Injury _________

❒ Hypertension ❒ Sleep Apnea ❒ IBS

❒ Other ______________________________________

Do you have any family members that are overweight or obese?

❒ Spouse ❒ Children x ______ ❒ Mother

❒ Father ❒ Siblings x ______ ❒ Other _________

For Women Only:

Do you have a gynecologist? ❒ No ❒ Yes: Provider Name:

____

Have they ever advised you to lose weight? ❒ Yes ❒ No

Are you pregnant or breast feeding? ❒ Yes ❒ No

Date of last menstrual cycle? ____________________

I understand I am responsible for payment when services are rendered. I have provided all information to the best of my knowledge.

Patient's Signature ____ Today's Date ____________________

CONSENT FOR MEDICAL TREATMENT AND
ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

This consent serves as confirmation that Physician's Plan Weight Loss + Wellness has discussed the nature and purpose of your medical treatment, the risks which may be associated, and that Physician's Plan has answered all of your questions in a satisfactory manner.

Please read carefully and complete this form. If you do not understand any portion of this form, please inquire and we will be glad to explain any information and/or answer any questions.

1. I hereby authorize and direct Physician's Plan, with assistants of their choice, to perform

   upon____the following medical treatment.

   (NAME OF PATIENT)

2. Physician's Plan combines nutritional counseling and education with the use of prescription medications to aid in appetite suppression.

3. Some of the reported risks known to be associated with the use of these medications include , but are not limited to:
   A) Insomnia
   B) Nausea, other GI Symptoms
   C) Headaches
   D) Dry Mouth
   E) Primary Pulmonary Hypertension (Very Rare Side Effect)

I have been informed of the probability of occurrence of each of the foregoing risks as the result of taking these medications.

I hereby state that I have read and understand this consent. All questions about the treatment program have been answered in a satisfactory manner, and all blanks were filled in prior to my signature.

This consent is valid until revoked by me in writing.

Patient's Signature:____Date: _________________________

I understand that photographs will be taken in order to document the program's effectiveness and results. I agree to allow any images taken to be used for testimonial purposes with the knowledge that my identity will be kept private.

Patient's signature:____Date: _________________________

Cancellation/No Show Appointment Policy

Physician's Plan requires at least a 24-hour notice to cancel a scheduled appointment. We understand that occasionally instances may arise that do not allow for a full 24-hour notice to cancel an appointment, however, we do continue to require a notification prior to scheduled appointment time to avoid being charged a fee.

In the event that an appointment is missed without prior notification, (either canceled or rescheduled) you will be charged $25.00 upon next visit.

Expiration Policy

All products and services will expire after one year of the purchase date.

I (print name)________________________, have read the above stated Physician's Plan Cancellation/No Show Appointment Policy and Expiration Policy. I fully understand that I will be charged $25.00 upon return visit for any previous no show, no call, appointments and that this policy will be strictly enforced. I also understand that all products and services purchased will expire within one year of the purchase date.

_________________________________ ________________

Patient's Signature