PATIENT INFORMATION

Name_____ Birth date_____

❒ Male ❒ Female Driver's License State & Number:_____

Mailing Address_____
(Street) (City) (State) (Zip)

Street Address (if different)_____
(Street) (City) (State) (Zip)

Home Phone: _____ **Email Address:** _____

Mobile Phone: _____

Work Phone: _____

All information will be kept confidential and only used to contact you. Phone support is important. We would also like to email reminders and our monthly newsletter.

Place of Employment_____ Occupation_____

How did you hear about Physician's Plan? ❒ Internet ❒ Television ❒ Facebook

❒ Friend/Family Member _____ ❒ Other_____

HEALTH HISTORY

How would you rate your overall health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Are you currently taking any medications (including birth control)? List name and dose _____

_____

Are you allergic to any medications? _____

Have you been seriously ill in the past 10 years? _____

Do you have any chronic health conditions? _____

Are you under a physician's care? ❒ Yes ❒ No If yes, name _____

Date of last routine physical? _____ Have you been advised by your physician to lose weight? ❒ Yes ❒ No

Does your physician know you are a patient here? ❒ Yes ❒ No May we contact and update your physician? ❒ Yes ❒ No

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

❒ Diabetes ❒ Arthritis ❒ High Cholesterol

❒ Heart Disease ❒ Thyroid Problems ❒ Injury _____

❒ High Blood Pressure ❒ Sleep Apnea ❒ Other _____

Do you smoke? If yes, for how long and how much _____

Do you drink alcohol? If yes, what kind and how many drinks per week _____

Have you ever taken any prescription diet medication? If yes, please list _____

Have you ever taken any over the counter diet medications before? If yes, please list _____

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

❒ Spouse ❒ Children (ages _____) ❒ Mother ❒ Father ❒ Siblings (#_____) ❒ Other

For Women Only:

Do you have a gynecologist? ❒ Yes ❒ No If yes, name _____

Date of last routine exam? _____ Have you been advised by your gynecologist to lose weight? ❒ Yes ❒ No

Does your gynecologist know you are a patient here? ❒ Yes ❒ No May we contact and update your gynecologist? ❒ Yes ❒ No

Are you pregnant or breast feeding? ❒ Yes ❒ No Date of last menstrual period? _____

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 _____

Physician's Plan
WEIGHT LOSS+WELLNESS

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: _____

Physician's Plan
WEIGHT LOSS+WELLNESS

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 Date