VIP Weight Loss & ANTI-AGING

Today's Date: ___ / ___ / ___ Primary Phone # _____-_____-_____ Alt# _____-_____-_____

Name: (last)_____(First)_____(MI)_____ DOB: ___ / ___ / ___

Address: _____City _____ State _____ Zip _____

Your email address: _____ Referred by: _____

Occupation: _____ Gender: M / F Height: _____ Weight: _____

Primary Care Provider/Clinic: _____ Last Exam Date: ___ / ___ / ___

Medical History (Please check all that apply)

Disease	No	You	Mom	Dad	Disease	No	You	Mom	Dad
High Blood Pressure					Asthma				
Chest Pain					Bronchitis				
*Heart Attack / Heart Failure					COPD				
Prostate Cancer					Depression / Anxiety				
Overactive Bladder					Diabetes				
Sleep Apnea					Gallbladder Removed				
Shortness of Breath					Gallstones				
Frequent Urination					High Cholesterol				
Lower Extremity Edema					Thyroid Disease				
Breast Cancer					Obesity				
Other Cancer:					Lupus				
Constipation					Painful / Difficult Urination				
Diarrhea					Prostate Enlargement (BPH)				
Blood Clots					Other:				

Surgical History

Year	Procedure	Reason	Location

Medication List (Including prescribed, over the counter and herbal remedies)

Drug Name	Strength of Drug	Frequency	Provider Name

DRUG ALLERGIES & Reactions:_____

Pharmacy Preference Name and Location: _____

Exercise Level: ____ Sedentary/None ____ Mild ____ Occasional Vigorous ____ Regular Vigorous

Tobacco Use Y / N if Yes, how often _____ Alcohol Use Y / N if Yes, how much _____

Emergency Contacts

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

How did you ear about us?

☐ Word of Mouth ☐ Mail Out ☐ Internet ☐ Sign

☐ Radio ☐ Television ☐ Newspaper ☐ Other: _____

Patient Signature: _____ Date: ___ / ___ / ___

Financial Agreement

The Financial Agreement is designed to inform you, the patient, of your financial responsibility. Payment is due at the time of services rendered. We gladly accept cash, Visa, MasterCard, American Express and personal check from a local bank.

I have read and understand the Financial Agreement as stated above and agree to my responsibility.

Patient's Signature: _____ Date: ___/___/___

HIPAA Privacy Notice

I have received a copy of the HIPAA privacy notice.

Patient's Signature: _____ Date: ___/___/___