***PLEASE FILL IN ALL FIELDS (MARK N/A IF UNKNOWN OR NOT APPLICABLE)**

NAME (first and last legal name)	**Drug Allergies:** **Food Allergies:**
ADDRESS: **City/State/ZIP:** **Email:**	**OCCUPATION INFORMATION** **Employer:** **Position:** **Full Time or Part Time:** **Shift: 1st 2nd Or 3rd (Please Circle)** **# Of Hours Per Day:**
BIRTHDATE __ __ /__ __ /__ __ __ __	
MOBILE PHONE# (__ __ __) __ __ __ - __ __ __ __	
Habits: Nicotine ☐**Yes** Use/Day: ☐**No**	**Exercise** ☐**Yes** ☐**No** Activity & Frequency:
Alcohol ☐**Yes** Frequency: ☐**No**	
Past or present misuse of drugs or alcohol ? ☐**Yes** ☐**No** ***If yes please explain:**	

LIST ALL SURGERIES/HOSPITALIZATIONS

DATE	SURGERIES/REASON FOR HOSPITAL STAY (WOMEN INCLUDE CHILDBIRTHS)	DATE	SURGERIES/HOSPITAL/CONTINUED
		PLEASE LIST FAMILY DOCTOR OR FACILITY	
		PLEASE LIST ANY SPECIALISTS YOU SEE	
		PREFERRED PHARMACY/LOCATION/PHONE	

************************OFFICE USE ONLY************************

SPECIFIC DIETARY PREFERENCES	DATE 1ST VISIT:
	STARTING WEIGHT:
	GOAL WEIGHT:

CHRONIC CONDITIONS		
1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.
FAMILY HISTORY:		

REGISTRATION INFORMATION

Name: __________________________ Date of Birth:________________

How did you hear about us?________________________ ***If you are interested in "Before Pics" please notify staff**

ALLERGIES

☐ NO KNOWN MEDICATION ALLERGIES

ALLERGIES	REACTION

Which of the following **chronic conditions** are **you** currently being treated for or have been treated for in the past?

☐ Acid reflux	☐ Depression	☐ Heart disease	☐ Migraines
☐ Allergies	☐ Diabetes	☐ Hyperthyroidism	☐ Sleep Apnea
☐ Anemia	☐ Seizures	☐ Hypothyroidism	☐ Stomach Ulcers
☐ Anxiety	☐ COPD	☐ High blood pressure	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ High Cholesterol	☐ Other:
☐ Asthma	☐ Heart Problems	☐ Irritable Bowel (IBS)	☐ Other:
☐ Back pain	☐ Heart murmur	☐ Insomnia	☐ Other:

Please check the box if you have experienced any of the following **symptoms** lately?

☐ Tiredness	☐ Losing Hair	☐ Sugar Cravings	☐ Stress
☐ Bloating	☐ Sleep Changes	☐ Lack of Energy	☐ Mood Changes
☐ Irregular Periods	☐ Uncontrolled nighttime eating	☐ Other:	☐ Other:

1. What is your GOAL weight? _______In your adult life what is the MOST you have weighed?________ The LEAST?______
2. Do you currently take a multivitamin? Y / N (circle one)
3. Do you sleep at least 8 hours a day? Y / N (circle one)
4. How often do you eat out per week? _______ Who does the cooking in your household?________ Which do you use most often? fresh foods or processed/pre-packaged foods (circle one)
5. Do you often skip meals? Y/N (circle one)
6. How long have you struggled with your weight? ___________
7. Have you ever been prescribed medications for weight loss? (**If so how long ago? how long did you use it? and how much weight did you lose?**)
   ____
8. Have you ever used diet programs such as? (please circle) Weight Watchers, Jenny Craig, Slim Fast, Nutrisystem, Medifast, Other_______
9. Why do you want to lose weight? (give us your top 3 reasons)

FAMILY HISTORY

Please (x) the appropriate box if anyone below has been treated for or is currently being treated for any of the following conditions

Illness	Father	Mother	Sibling	Grandparent
Heart disease				
High cholesterol				
High blood pressure				
Diabetes				
Heart attack				
Stroke				
Asthma				
Cancer				
Seizures/Epilepsy				
Obese or Overweight				
Other:				

Patients Name: ____

Medications Flowsheet

Date of Birth: ____

Allergies:____

Please List Your Medication Name, Dose & How Often You Take It In The First Column On The Left

For office use only on this side mark date verified/changed/d/c'd

Medication & Dose - Frequency										

Name: ____**Date of Birth**______________

HIPAA PRIVACY AUTHORIZATION

Appointment information:		
May we:	**Yes**	**No**
Leave message mobile phone?	☐	☐
Send via text message?	☐	☐
Leave with another person (see below)	☐	☐
Send through the mail?	☐	☐
Send via E-mail? *please note if you signed up online you will always receive appointment reminders via email – you can deactivate this by deactivating your online scheduling account.	☐	☐

Medical information and results: such as lab reports (normal and abnormal), x-rays, medication information (if necessary)		
May we:	Yes	No
Leave message on mobile phone?	☐	☐
Send via text message?	☐	☐
Leave with another person? (see below)	☐	☐
Send through the mail?	☐	☐
Send via E-mail?	☐	☐

Would you like to receive helpful weight loss information and encouragement as well as special offers or discounts

via email? (opt out anytime)	Yes ☐	No ☐
via mail? (opt out anytime)	Yes ☐	No ☐
via text? (opt out anytime)	Yes ☐	No ☐

Please list the individuals who we may leave the above information with:

Name	Emergency contact?	Relationship to Patient	Phone Number	Appointment information (check if yes)	Medical information (check if yes)
	☐			☐	☐
	☐			☐	☐
	☐			☐	☐

Please fill this out entirely and sign and date at the bottom, recognizing that you are aware of HIPAA and Confidentiality requirements.

SIGNATURE: ____DATE: ____

Written Financial Policy

Thank you for choosing Medical Weight Loss Center of Harrisburg. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Visa®, MasterCard®, American Express®, Discover Card® or CareCredit® Healthcare Card
- Convenient Monthly Payment Plans[1] from CareCredit
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

- There are no refunds on services rendered or medications.
- We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.
- Keep in mind that your insurance policy is basically a contract between you and your insurance company. At this time we will not file your insurance claim for you.

1. If payment on your account is 30 days late, a 1.5% interest rate per month will be assessed.
2. If you cancel an appointment with less than 24 hours' notice, you may be charged a $45 fee. This fee will have to be paid before you can make another appointment.
3. If you fail to cancel any appointment or arrive very late you may be charged a $55 fee, which will have to be paid before you can make another appointment.
4. **If you have a package with visits** and you miss a scheduled appointment without cancelling or you cancel without 24 hours' notice, a visit will be removed from your package as a charge for the "No Show".
5. We reserve the right to contact collection agencies to retrieve past due balances. You will be responsible for any collection and attorney's fees and costs if collection becomes necessary.
6. We do not accept checks as payment for services.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

The information asked for in this packet is for use by your healthcare provider to create safe and effective treatment plans. It will be kept as part of your confidential medical record.

By signing below I attest that I am giving accurate information on my identity, medications and medical history. I acknowledge that failure to do so could cause me bodily harm and or risk my discharge from this practice. It is recommended that I notify my primary care provider of all providers I am seeing, including, Medical Weight Loss Center of Harrisburg. If I do not feel comfortable informing my primary care provider of my treatment, I know I can fill out a release form asking Medical Weight Loss Center or its providers to inform my primary care provider for me.

____

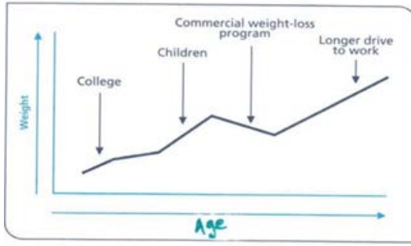
Patient, Parent or Guardian Signature   Date

____

Patient Name (Please Print)

[1]Subject to credit approval

Example:



WEIGHT GRAPH

Name:________________________

Fill in the following graph to the best of your ability for each age category then label the changes as seen in the example.

Include pre & post pregnancy, weight loss programs, changes in medication, work, stress, hormones etc.

WEIGHT vs AGE

WEIGHT: 420, 410, 400, 390, 380, 370, 360, 350, 340, 330, 320, 310, 300, 290, 280, 270, 260, 250, 240, 230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

child, teens, 20-25, 26-30, 31-35, 36-40, 41-45, 46-50, 51-55, 56-60, 61-65, 66-70, 71-75

AGE