



Weight Loss Patient Information

Patient Name: _____ Date of Birth _____ Age _____ Gender M F

Current Height: _____ inches Current Weight: _____ lbs. Goal Weight: _____ lbs.

Guardian (if minor): _____ Relationship: _____

Patient Address: _____
Street Address

_____ City State Zip

Contact Information: _____
Mobile Phone

May we leave a voice message for you on this phone, including medical information? _____ Yes _____ No

Email Address: _____ May we contact you with information? ___Y ___N

Emergency Contact Information: _____
Name Phone Relationship

With whom may we leave a message regarding your medical information? _____ No one

Designated Person Only: _____
Name Phone Relationship

May we send you a reminder email, voice mail, or postcard (no medical or personal information)? _____ Yes _____ No

Please tell us how you found out about us:

___ Web site ___ Patient Brochure ___ Print Ad(s): ___ Google/Ads ___ Facebook ___ Other Social Media

___ Public Presentation ___ Work or live in the area

___ Referral by physician: _____

___ Referral by patient: _____

___ Other: _____

Please list any known drug allergies: ___ No Drug Allergies

Have you been vaccinated against Covid-19? ___Y ___ N

For complete records, we may need to make a copy of a suitable ID (Driver's License).

Signature of Patient

_____ Date _____

Please complete all pages in this packet