Date _____
InBody ID _____
Chart # _____
☐ Scanned into EMR

360 Medical Weight Specialists
New Patient Registration Forms

PATIENT INFORMATION

Name _____ Name you prefer to be called _____ Sex: M F

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Birthdate ____ / ____ / ____ Age _____ Height _____ Email _____

Education: Elementary High School/Technical School 2-yr College 4-yr College Grad School
(circle highest level achieved)

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Work Phone: _____ Ext. _____

REFERRAL

How did you hear about us? _____
(If a friend or another physician please include name)

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

Spouse Name: _____ Phone: _____

Is it okay to share medical information with your spouse? Yes No

Primary Care Physician: _____ Location:_____ Phone: _____

Is it okay to contact your primary care physician to discuss your treatment? Yes No

MEDICAL HISTORY

1. Are you in good health at the present time to the best of your knowledge? Yes No
   Explain a *no* answer: _____
   _____
2. Do you have any medical problems? Yes No
   If *yes*, please list: _____
   _____
3. Have you been treated by a psychiatrist and/or psychologist? Yes No
   If *yes*, for what? _____
   _____
4. Any Surgery? Yes No
   If *yes*, please specify (list all):
   Date Surgery

5. Are you taking any prescribed medications at the present time? Yes No

If *yes*, please specify (list all):

Prescription Drug Dosage

6. Are you taking any over-the-counter medications, vitamins, and/or supplements? Yes No

If *yes*, please specify (list all):

Product Dosage

7. Any allergies to any medications? Yes No

If *yes*, please specify (list all): _____

_____

8. History of Heart Attack or Chest Pain or other heart condition? Yes No
9. History of Glaucoma? Yes No
10. Date of last menstrual cycle_____
11. Are you currently pregnant? Yes No
12. Are you currently breastfeeding? Yes No
13. Gynecologic History: Yes No

Birth Year(s): _____

NUTRITION EVALUATION

14. What is your desired weight? _____ lbs
15. In what time frame would you like to be at your desired weight? _____
16. What is the most you have ever weighed (non-pregnant)? _____ lbs at _____ yrs. old
17. Have you tried other diets before? Yes No

If *yes*, please specify (list all): _____

_____

18. Food(s) you crave: _____

_____

19. Do you drink coffee or tea? Yes No

If *yes*, how much daily? _____

20. Do you drink soda? Yes No

If yes, how much daily? _____

21. Do you drink alcohol? Yes No

If *yes*, average drinks consumed per week: 1-3 3-5 6 or more

Type? _____

22. Do you smoke? Yes No Quit
23. Do you exercise? Yes No

If *yes*, what type? _____

24. On average, how many hours of sleep do you get per day? _____

WEIGHT LOSS PROGRAM CONSENT

I, _____ , authorize Dr. Gartner, and whomever she designate as her assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Name (Please Print)	Patient's Signature	Date

FINANCIAL POLICY

Thank you for selecting 360 Medical Weight Specialists for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. All visits must be used within the six months of the payment date. I have read and understand all of the above and have agreed to these statements.

Name (Please Print)	Patient's Signature	Date

COMMUNICATION VIA EMAIL CONSENT

I, _____, herby consent to have Dr. Gartner, and whomever she designates as her assistants, communicate with me via e-mail regarding the following aspects of my medical care and treatment: lab results, prescriptions, appointments, billing, etc. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians and physician assistants regarding my medical care, treatment and/or scheduling may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not reply on e-mail. I have read and understand all of the above and have agreed to these statements.

Name (Please Print)	Patient's Signature	Date

SOCIAL MEDIA POLICY

I,_____, hereby consent to have Dr. Gartner, and her staff representatives, communicate with me via social media (including but not limited to Facebook, Yelp, Real Self, or Instagram) as a tool for support and guidance. I further understand that there is a risk that social media communications between my physician and me or members of my physician's office staff, or between me and other patients, may be visible within social media accounts. I understand that in an urgent or emergent situation I should call my primary care provider or go to the Emergency Room and not reply on social media. I have read and understand all of the above and have agreed to these statements.

Name (Please Print)	Patient's Signature	Date