Renew Weight Loss Patient Registration

Office Use Only

Date:

Entered By:

▫ Mr ▫Miss ▫ Mrs. ▫Ms ▫ Dr.

Last Name: First: Middle:

Marital status: ▫ Single ▫ Mar ▫ Div ▫ Sep ▫ Wid ▫ Part

Gender: ▫ M ▫ F

Birth Date: / /

Age:

Email Address:

Address:

Address (2):

City: State: Zip:

Phone Number: ( )

Mobile Number: ( )

Fax Number: ( )

Occupation:

Employer:

Work Number: ( )

Contacting You

May we call you? ▫ Yes ▫ No
Leave messages? ▫ Yes ▫ No
May we email you? ▫ Yes ▫ No
May we mail you? ▫ Yes ▫ No

How did you hear about Renew Weight Loss?
▫ Billboard ▫ Coupon ▫ Direct Mailing Employee ▫ Internet ▫ M.D./Doctor ▫ Magazine
▫ Newspaper ▫ Patient/Friend ▫ Radio ▫ T.V. ▫ Walk-In ▫Other

Emergency Contact

Local Friend/Relative: Relationship: Phone Number: ( ) Work Number: ( )

Insurance Information

Medical insurance policies do not typically cover weight management care and related expenses, including laboratory testing, electrocardiograms, prescription medication and related supplements. If your primary diagnosis is obesity, you may not bill your insurance company for a comorbid condition. Doing so may result in a charge of fraud against you and/or the physician.

An appropriate receipt of payment will be provided, including a charges and descriptions of the office visit for the different levels of service provided. The codes used for this purpose may or may not correspond to the codes used by the insurance companies.

Changes to “codes” will not be made for the use of any insurance company. Insurance companies may reimburse patients for expenses related to weight management, for instance if co-morbid conditions are also part of the weight management treatment, but reimbursement will not be made from the insurance company to the physician. Again, please understand that Renew Weight Loss will not present a bill to any insurance company for weight management services or related charges. Also, Renew Weight Loss will provide what is considered an appropriate receipt, as above described and is not obligated to complete any form that may be provided by a health insurance company sent to the patient or physician in this regard.

If you are covered by MEDICARE INSURANCE you must complete and sign an informed waiver prior to participation in this Weight Management Program.

Medicare Beneficiary

Are you currently a beneficiary of Medicare? ▫ Yes ▫ No

Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in Renew Weight Loss program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics and limitations as described in this document. I accept these specific policy rules.

By signing below, I am indicating that I have also read and fully understand the HIPAA Notice of Privacy Practices for Renew Weight Loss and have not requested a copy.

Patient/Guardian Signature: Date:

Printed Name: If you are a guardian, what is your relationship to the patient?

Renew Weight Loss Patient History

Last Name: First Name: Middle : Gender: ▫ M ▫ F Birth Date: / / Age:

Primary Physician/Referral : Physician Phone Number: ( )

Optometrist/Ophthalmologist: Ophthalmologist Phone Number: ( )

Last Physical : Last EKG: Last Eye Exam:

Weight:

Goal Weight:

Health History

	Family	Personal		Family	Personal		Family	Personal
Alcohol Abuse	▫	▫	Dizzy Spells	▫	▫	Irregular Pulse	▫	▫
Anemia	▫	▫	Drug Abuse	▫	▫	Kidney Disease	▫	▫
Arthritis	▫	▫	Eating Disorder	▫	▫	Liver Disease	▫	▫
Asthma	▫	▫	Epilepsy	▫	▫	Lung Disease	▫	▫
Bleeding Disorder	▫	▫	Fainting Spells	▫	▫	Mental Illness	▫	▫
Bloody Stool	▫	▫	Fatigue	▫	▫	Migraines	▫	▫
Bronchitis	▫	▫	Frequent Urination	▫	▫	Moodiness	▫	▫
Cancer	▫	▫	Gallbladder Disorder	▫	▫	Nervousness	▫	▫
Chest Pain	▫	▫	Glaucoma	▫	▫	Obesity	▫	▫
Constipation	▫	▫	Headaches	▫	▫	Palpitations	▫	▫
Convulsions	▫	▫	Heart Disease	▫	▫	Rashes	▫	▫
Depression	▫	▫	High Cholesterol	▫	▫	Shortness of Breath	▫	▫
Diabetes	▫	▫	Hypertension	▫	▫	Stroke	▫	▫
Diarrhea	▫	▫	Insomnia	▫	▫	Thyroid Disease	▫	▫

Comments /Other:

Surgeries & Other Hospitalizations		
Year	Reason/Diagnosis	Hospital
Prescribed Medications & Over-the-Counter drugs, dietary supplements (including vitamin s, inhalers, ect)		
Medication Name	Strength	Frequency
Medication Allergies		

Women Only				
How old were you at onset of menstruation?	Date of last menstruation?			
How often do you get your period (days)?	Number of Pregnancies :	Number of live births :		
Heavy periods, irregularity, spotting, pain, or discharge?			▫ Yes	▫ No
Are you pregnant, trying for pregnancy, or breastfeeding			▫ Yes	▫ No

Behavior Style		**Please select only one answer.**
▫ You are always calm and easygoing ▫ You are seldom calm and persistently driving for advancement	▫ You are usually calm and easygoing ▫ You are never calm and have overwhelming ambition	▫ You are sometimes calm and easygoing ▫ You are hard-driving and never relax

Health Habits & Personal Safety	**This section is optional. All answers will be kept strictly confidential.**

Exercise	▫ Sedentary (no exercise				
	▫ Mild Exercise (i .e. climbing stairs, walking three blocks , golf				
	▫ Occasional vigorous exercise (i .e., work or recreation less than 4 times per week for 30 minutes)				
	▫ Regular vigorous exercise (i .e., work or recreation 4 times per week or more for 30 minutes or more)				
Diet	Are you dieting?			▫ Yes	▫ No
	If yes, are you on a physician-prescribed medical diet?			▫ Yes	▫ No
	How many meal s do you eat i n an average day?				
	Rank your salt intake:		▫ High	▫ Medium	▫ Low
	Rank your fat intake:		▫ High	▫ Medium	▫ Low
Caffeine	Rank your caffeine intake:	▫ High	▫ Medium	▫ Low	
	What types of caffeine do you drink?				
	How many cups /cans per day?				
Alcohol	Do you drink alcohol?			▫ Yes	▫ No
	If yes, what kind?		▫ Bear	▫ Liquid	▫ Wine
	Do you use tobacco?				

Tobacco	How many years ?				
	▫ Cigarettes–packs /day: ▫ Chew –per/day:		▫ Pipe–#/day:		▫ Cigars–#/day:
	If you previously used tobacco, what year did you quit?				
Drugs	Have you ever taken street drugs with a needle?			▫ Yes	▫ No
	Do you currently use recreational or street drugs?			▫ Yes	▫ No
Sex	Are you sexually active?			▫ Yes	▫ No
	If yes , are you trying for a pregnancy?			▫ Yes	▫ No
	If you are not trying for a pregnancy, what contraceptive methods are you using?				

Weight History	
Past weight loss attempts and/or diets	Date
What is the main reason you decided to lose weight?	
When did you begin gaining excess weight (give reasons if known)?	
What do you think is the main cause of your weight problems?	
Is your spouse, fiancé, or partner overweight?	
How often do you dine out? What restaurants do you frequent? What types of food do you eat there?	
List any food allergies	

What foods do you avoid? What foods do you crave?
Do you awaken hungry during the night?
What are your worst food habits? What are your snack habits?
Rate your body from 1 to 10. How would you describe your body?
If you can change one thing about your body, what would it be?
What do you feel will be your obstacle(s) to successful weight loss ?
What is your typical breakfast? What time? Where? With whom?
What is your typical lunch? What time? Where? With whom?
What is your typical dinner? What time? Where? With whom?
Add any additional comments :

Accuracy Agreement	
I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.	
Signature:	**Date:**

Thank You.

This information will assist us in establishing your medical history and identifying problem areas.

Thank you for your time and patience in completing this form.