Senza WEIGHT LOSS

New Patient Weight Loss Intake Form

Basic Patient Information

Name:		Date:	
Street Address:			
City:		State:	Zip:
Home Phone:	Cell Phone:		
Email Address: t			
Sex: M ☐ F ☐	Birth date:	Height:	Weight:
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced			
Occupation: retired			
How did you hear about us? ad			
Primary Care Physician:		Ph.#	
Emergency Contact:	Ph.#	Relationship:	

Health and Wellness History

Has your doctor advised you to lose weight?		
Do you have any dietary restrictions? Please explain:	☐ Yes	☐ No
How often do you exercise?	What type of exercise?	
Do you feel stressed? Please explain:	☐ Yes	☐ No
Check ALL that apply to you: ☐ Pregnant ☐ Might Be Pregnant ☐ Breast Feeding ☐ Currently Undergoing Chemotherapy		

Please answer the following questions honestly so we can do our best to help you reach your goals.

How much weight do you want to lose? ___

Check **ALL** health problems you have had or currently have:

- ☐ Diabetes
- ☐ Fatty Liver Disease
- ☐ Gall bladder
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Blood Sugar
- ☐ Irritable Bowel
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Low Blood Sugar
- ☐ Stroke

Other: _____

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List **ALL** medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	For what conditions?

Please list all ***known DRUG and FOOD allergies***:

Drug Name/Food Name:	Reaction:

Patient Name - Please Print

Date

Signature of Patient

Date

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AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____ No_____

I fully understand that my signature is consent and authorization to be examined by Senza's medical associate or to participate in a telephone consult.

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Signature _____ Date _____

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment you provide a 24 hour notice. Appointments which are cancelled within less than 24 hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that IF unavoidable circumstances may cause you to cancel with less than a 24-hour notice fees may be waived upon management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no show fees can be directed to the front desk at (208) 521-8393.

Please sign that you have read, understand and agree to this cancellation and no-show policy.

_____

Patient Name (Please Print) Date

_____

Signature of Patient Date