Today's Date _____

Welcome to Integrated Medical Weight Loss!

Name _____ Date of Birth: _____ Sex: M / F

Home Address (City, State & Zip): _____

Email Address: _____

Cell Phone: _____ Home: _____ Work: _____

Employer Name/Address: _____ Occupation: _____

Circle One: *Minor Single Married Divorced Widowed Separated* ~ Name of Spouse: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about us? _____

Primary Care Physician (name & address): _____

Primary Insurance Co: _____ Secondary Insurance: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Appointment Confirmation ~ Preferred Contact Method: ☐ Text ☐ Phone Call (cell or home) ☐ Email

Permission to leave information on: ☐Cell Phone ☐Home Phone ☐Email **Initial for approval** _____

List All Medical Problems Medication for Problem / Dose Healthcare Provider for Problem

_____

_____

_____

_____

_____

_____

_____

Vitamins / Over the Counter Medication: _____

Allergies to Medications: _____

Mental/Emotional Problems Medication for Problem Healthcare Provider for Problem

_____

_____

List Any Surgeries Surgeon Year of Surgery

_____

_____

_____

Number of Pregnancies: _____ # of Miscarriages ?:_____ Complications? _____

Date of Last Physical: _____ Last Blood work: _____ Last EKG: _____

Have you had a Stress Test? _____ Results: _____ Sleep Study? _____ Results: _____

Have you had an "echo" ultrasound of your heart? _____

Have you ever taken Phen-fen / Redux? _____

School & Work History: _____

Hobbies: _____

Who lives with you? _____ Are you safe there: _____

Did / Do you smoke: Y N If so, # of packs/day: _____ Age Started: _____ Age Stopped: _____

Servings of Alcohol per day: _____ Other drug use: _____

Hours of sleep per night: _____ Do you think you have a problem with sleep? _____

Exercise: _____

Family Medical History **Age** **Medical Problem** **If deceased—Age & Cause of death**

Father: _____

Mother: _____

Sisters: _____

_____

Brothers: _____

_____

Children: _____

_____

Spouse: _____

Other Important Family History: _____

When did your weight problem begin? _____ Highest weight (not pregnant): _____

Weight Loss Attempts:

Amount Lost **When?** **What Method?"** **Amount Maintained** **Amount Regained**

_____

_____

_____

_____

List Weight Gains: **When ?** **Why do you think you gained ?**

_____ _____

_____ _____

Are there food/eating triggers in your environment, including other people's habits? _____

Do you ever feel like you "know what to do, but just can't do it" when it comes to eating well? _____

Explain: _____

Do you think you have a problem with: **stress, emotional, mindless** or **compulsive eating**? (Circle all that apply) **Y / N**

Do you believe food or eating can be addictive for someone? _____ Do you think it is for you? _____

What is your most important / strongest motivation to lose weight?_____

How do you think we can help you lose weight? _____

Review of Systems - Please indicate personal history below: **Name:** _____

Constitutional Systems

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic Sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Cardiovascular

Heart trouble	No	Yes
chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking	No	Yes
Shortness of breath lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

Respiratory

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more then 3 weeks)?	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain w/periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes
Female - date of last pap smear	No	Yes

Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

Integumentary (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose Veins	No	Yes
Brest pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Neurological

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness of tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head Injury	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
Suicidal Thoughts	No	Yes
Violent or Unusual Thoughts	No	Yes

Endocrine

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

Hemotologic/Lymphatic

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

Allergic/Immunologic

(History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol or other Narcotics	No	Yes
Novacain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications:

_____

_____

Known food allergies:

_____

_____

Environmental allergies:

_____

_____

Past Medical History (Have you ever had the following):

Measles.....	no	yes	Anemia.....	no	yes	High Blood Pressure.....	no	yes	Kidney Disease.....	no	yes
Mumps.....	no	yes	Bladder Infections.....	no	yes	Low Blood Pressure.....	no	yes	Thyroid Disease.....	no	yes
Chickenpox.....	no	yes	Epilepsy.....	no	yes	Hemorrhoids.....	no	yes	Bleeding Tendency....	no	yes
Whooping Cough.....	no	yes	Migraines.....	no	yes	Asthma.....	no	yes	Other (please list):	no	yes
Scarlet Fever.....	no	yes	Tuberculosis.....	no	yes	Hives or Exzema.....	no	yes			
Diptheria.....	no	yes	Diabetes.....	no	yes	AIDS or HIV+.....	no	yes			
Smallpox.....	no	yes	Cancer.....	no	yes	Infectious Mono.....	no	yes			
Pneumonia.....	no	yes	Polio.....	no	yes	Bronchitis.....	no	yes			
Rheumatic Fever.....	no	yes	Glaucoma.....	no	yes	Mitral Valve Prolapse...	no	yes			
Heart Disease.....	no	yes	Hernia.....	no	yes	Stroke.....	no	yes			
Arthritis.....	no	yes	Blood Transfusions...	no	yes	Hepatitis.....	no	yes			
Venereal Disease.....	no	yes	Back Pain.....	no	yes	Ulcer.....	no	yes			

INTEGRATED MEDICAL WEIGHT LOSS
Your permanent weight loss is our passion

Integrated Medical Weight Loss

Patient Authorization to Disclose Personal Health Information (PHI)

Patient: _____
(First Name) (Middle Initial) (Last Name)

Address: _____

Date of Birth: _____

Integrated Medical Weight Loss/Yestermorrow PC is authorized to **RELEASE TO / OBTAIN FROM** (circle desired choice/s):

Recipient/Discloser: _____
Primary Care Physician (use separate form for add'l doctor's)

_____

For the Purpose of : _____
(optional)

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- ☐ I GIVE PERMISSION TO RELEASE **ALL** MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, Sexually Transmitted Infections (STI), Physical or Sexual assaults, communications to Physicians, Registered Nurse Practitioners, social workers and/or psychotherapies, psychologists, if any.

- ☐ I GIVE PERMISSION TO DISCLOSE and/or RELEASE **ONLY** RECORDS specifically described below (check all that apply):

  ☐*Consultations* ☐*EKG* ☐*History and Physical* ☐*Outpatient Reports* ☐*Emergency Reports* ☐*Operative Reports* ☐*X-ray Results* ☐*Laboratory Reports* ☐*Pathology Reports* ☐*Mental Illness* ☐*OT/PT* ☐*Speech,Audiology* ☐*Cardiac Rehab records* ☐*Sexually Transmitted Infections* ☐*Alcohol or Drug Treatment Test results & treatment* ☐*Human Immunodeficiency Virus (HIV)*

I release Integrated Medical Weight Loss/Yestermorrow PC, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Integrated Medical Weight Loss/Yestermorrow P.C., provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ (Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

_____
Patient Signature (Patient's Representative if minor) Date

INTEGRATED MEDICAL WEIGHT LOSS
Your permanent weight loss is our passion

Patient: _____

1. Financial Policy

We are happy you have chosen Integrated Medical Weight Loss for your healthcare and weight loss needs, and are looking forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. We suggest you contact your insurance company with any questions you may have regarding your coverage. If you are not insured by a plan we participate with, payment in full is expected at each visit. As a convenience, we offer discounted rates for self-pay patients.

Co-Payments and Deductibles: All co-payments and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Thank you for understanding our payment policy. Please contact us if you have any questions or concerns.

~ I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____
Signature of Patient or Responsible Party Date

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2. Acknowledgement of Privacy Practice (HIPAA)

By signing below, I am consenting to allow Integrated Medical Weight Loss to use and disclose my PHI to carry out treatment, payment and healthcare operations. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read. I understand the Notice of Privacy Practices and agree to its terms.

_____ _____
Signature of Patient or Responsible Party Date

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3. PHI Disclosure Designation

I agree that Integrated Medical Weight Loss may disclose certain areas of my health information to a personal representative noted below, since such person is involved with my healthcare or financial responsibility related to my healthcare.

_____ _____
Name of Contact Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date

INTEGRATED MEDICAL WEIGHT LOSS
Your permanent weight loss is our passion

Patient Name _____

24 Hour Cancellation Policy

If you cannot make your scheduled appointment, kindly call the office within 24 hours to cancel or reschedule that appointment.

In accordance with this cancellation policy, please understand if you do not show up for your scheduled appointment or fail to call and cancel the appointment within a 24 hour time frame, your credit card will be charged with the appropriate fee as noted below:

Dr. Rocchio: $75.00
NPs - Patrice French or Jennifer McCaskie: $55.00
Nancy Sceery, RD: $55.00

I hereby authorize Integrated Medical Weight Loss / Yestermorrow, PC to charge the credit/debit card listed below if I do not show up for a scheduled appointment or cancel in less than 24 hours. I understand that this is a one time or periodic charge that will be made as indicated above. I guarantee and warrant that I am the legal cardholder for this credit/debit card and that I am legally authorized to enter into this one-time or billing agreement. I understand that this office will not charge my credit card for anything more than $75.00 per incident and only for the reason set forth in this agreement.

Thank you for your understanding and cooperation with this policy.

_____ _____
Signature of Patient or Responsible Party Date

****

Credit Card Information & Authorization

☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Card Holder name (as shown on card): _____

Billing Address: _____
Street City State Zipcode

Credit Card #: _____ Expiration Date: _____

_____ _____
Signature of Card Holder (Required) Date

Updated 6.5.17