Family Doctors
MEDICAL CENTER

DEMOGRAPHICS: **Date:_____________**

Full Name:

Social Security #: Date of Birth:

Gender: _____ M ______ F Marital Status: _______________

Address: Apt#.:

City: State: Zip Code:

Home Phone: Cell Phone:

Emergency Contact Name: Phone #:

E- mail:

How did you hear about us?

HISTORY:

Any History/Current Medical Illness? _______ Y es ________ No
If Yes, please check if applicable:

☐ Heart Disease ☐ Hypertension/High BP ☐ Blood Disease

☐ Stroke/Aneurysm ☐ Diabetes ☐ Cancer

Other:

List Current Medications

Are you allergic to any medications? ________ Yes ______ No

If yes, please list them below:If yes, please list them below:

What is your ideal weight? ______________ lbs.

What weight loss program have you decided to register in? (please check program desired)

MEDICATION PROGRAM * ☐ *CASH ☐ HCG 26 Day Program
☐ *WITH INSURANCE ☐ HCG 43 Day Program

INSURANCE NAME:

ID #:

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Weight Loss Program

Financial Agreement

Fees: Patient financial responsibility is due prior to services being rendered. Any patient prior balance would also be due at time of service. If you are unable to provide payment at the time of service, you may speak with front desk staff to reschedule your appointment or to make payment arrangements on prior balance.

I understand and agree that I am declining to use a health benefit plan and will be charged based on cash price and all patient financial responsibility must be paid prior to services being rendered.

_____Initial

Pricing: (Subject to change at any time)

WLP Program : $149	WLP Program : $299.00
• InBody Composition Analysis • Physician Office Visit • EKG (as determined by provider) • 30-day of RX's determined by provider	• InBody Composition Analysis • Physician Office Visit • EKG (as determined by provider) • 30-day of RX's determined by provider • Leptin Supplements • Weekly Nurse Visits of B12 and Lipo (MIC) injections

____________________	____________________	____________________	____________________
Name	DOB	Signature	Date