NAPERVILLE WEIGHTLOSS CENTER

NEW PATIENT INFORMATION

PATIENT:

Name: _____
Last First Middle

Address: _____
City: _____State: _____ Zip:_____
Phone: (___)_____Alt #(___)_____
Email: _____
DOB: _____ Age:_____ Sex: M F
Occupation: _____

EMERGENCY CONTACT:
(You must list at least one person)

Name: _____
Relationship: _____
Phone #: _____

PHARMACY INFORMATION:

Pharmacy: _____

Phone #: _____

GETTING TO KNOW YOU:

Do you have family members or friends who may need to lose weight? If so please list names.

1. _____ # _____
2. _____ # _____

How did you hear about our office? (Check one)

___Family or Friend*
___Newspaper
___Living Social
___Deal Saver
___Groupon
___Valpak
___Money Mailer
___Other_____
___Door Hanger
___Sign out Front
___Internet
___Doctor Referral
___TV
___Radio
___Website

***Referral Name**:_____

Insurance Plan:_____

CONSENT SIGNATURES:

_____
Signature

_____
Date

_____
Witness

CONSENT TO PARTICIPATE

I have met with a member of the medical staff, have reviewed the literature associated with the program and have been given the opportunity to have all of my questions regarding the weight loss program answered. All of the medical/surgical information I have given to the doctors and Staff at Naperville Weightloss Center is correct and complete to the best of my knowledge. I understand this program includes diet, exercise, behavioral and lifestyle changes, and appetite suppressants, when appropriate. I understand that the abuse or overuse of appetite suppressants is potentially life threatening and illegal. Appetite suppressants are controlled substances that are regulated by State and Federal Laws. I understand that it is illegal to obtain appetite suppressants from more than one physician or clinic and agree I will not obtain any appetite suppressants from other prescribing physicians or have appetite suppressant prescriptions filled from multiple pharmacies. I understand that if I participate in the acquisition of appetite suppressants from multiple healthcare providers for any reason, I am participating in an illegal action and may be held liable for criminal activity. _____Patient initials

I understand that medications used in this program may cause or aggravate high blood pressure or alter Insulin requirements in diabetics, and that both Hypertension and Diabetes may improve with weight loss. I understand that, although unusual, there may be adverse reactions to the medications, including rapid heart rate, restlessness, agitation, poor sleeping, dizziness, headaches, blurred vision, psychotic states, dryness of the mouth, constipation, /diarrhea, nausea, stomach pains, frequent urination or discomfort urinating or changes in sex drive. I understand that weight loss alone carries some risk, including; gall bladder disease. If I should have any other questions about the medications prescribed to me at this office, I will ask the attending provider or staff member for the answer. Subsequent to leaving the office, I will notify th the staff immediately if I have further questions. I also know to stop taking the medications IMMEDIATELY and report to this office if any of the following occurs: decreased exercise tolerance, leg swelling, and unexplained shortness of breath, chest pain, blurred vision, or consciousness.

_____Patient Initials

I understand that dietary management and physical exercise are necessary components of this program and must be utilized for optimum results. I have not been given any guarantees or promises regarding the expectations or results for me in this weight loss program. I freely and voluntarily consent to participate and agree to follow the instructions given. _____Patient Initials

Additionally, I will not hold Naperville Weightloss Center, the company owners, associates or employees liable for my health and or weight loss. I also confirm that I am under the care of my own primary care physician as well and agree that I will not change dosages or frequency of medications prescribed and will notify the staff of Naperville Weightloss Center of any changes in medications immediately. I also understand that Naperville Weightloss Center reserves the right to change my medications at anytime as deemed medically necessary, per the staff's discretion.

_____Patient Initials

WOMEN ONLY: I have been informed that I should **NOT** get pregnant while on this medication and I confirm that I am NOT pregnant or trying to get pregnant at this time and that if I do not disclose this information to the staff, that the medications I could be prescribed could be harmful or fatal to the fetus. I will not try to get pregnant while taking any prescribed medications prescribed by Naperville Weightloss Center and I agree to hold Naperville Weightloss Center harmless from any claims or lawsuits if I should get pregnant while taking medications prescribed by Naperville Weightloss Ctr.

_____Patient Initials

NP