Patient Information Sheet

*Please fill out this form in print and answer as many questions as possible. Items in **BOLD** are **REQUIRED.***

Legal Last Name:	**First Name**:	**MI**:
Marital Status (Circle One): Single Married _______	**Sex** (Circle One): Male Female	
Date of Birth: / /	**Social Security Number:** - -	
Street Address:		**Apt.#:**
City:	**State:**	**Zip Code:**
Home Phone:	**Work Phone:**	**Cell Phone:**
Employer:	**Your Email:**	
How were you referred to our program? (Circle One): Groupon Living Social Yelp Internet LVAC		
Family/Friend Referring Friend/Relative's Name:	**Other:**	

If the Patient is Under 18 years of age, please answer the following questions:

Guardians Name:	Guardian's SS#:
Guardian's DOB: / /	Guardian's Home Address:

Emergency Contact

Name:	**Relationship:**	**Phone:**

The above information is true to the best of my knowledge.

I understand the weight loss and anti-aging programs provided by TrimBodyMD are generally considered an elective program. TrimBodyMD are not credentialed with any insurance company and are "CASH PAY ONLY PROGRAMS", which is not usually covered by an insurance policy. TrimBodyMD is an elective program that does NOT bill insurance carriers. Payment for services rendered are Due at the Time Services are Rendered.

Printed Name: ____________________ Signature: ____________________ Date Signed: ____________

Patient Name: ______________________ Date: ______________________

PRESENT MEDICAL HISTORY

Are you under a doctor's care at the present time? Yes / No
If yes, for what: ____

Are you currently in a pain management program or on disability? Yes / No

Do you have a family/primary care physician (PCP) in the Las Vegas area? Yes / No
If yes, physician name: ____

Are you taking any prescribed medications at the present time? Yes/No

Med: ____________________ Dosage: _________ Med: ____________________ Dosage: _________

Med: ____________________ Dosage: _________ Med: ____________________ Dosage: _________

Are you pregnant? (Females Only) Yes / No

Are you currently on hormone replacement therapy (HRT)? Yes / No
(Includes Birth Control)
Estrogen: _______ Progesterone: _________ Testosterone:_________
Growth Hormone: _______ BCP: __________ Other: _________

Are you currently taking any vitamin or health supplements? Yes / No
_______Multivitamin _______L-Carnitine _______CLA _______Anti-oxidants
_______Protein bars/shakes Other:______________________________________

Do you have any allergies or adverse reactions to medications or substances (such as latex)? Yes / No

Med: ______________________________ Reaction: ______________________________

Med: ______________________________ Reaction: ______________________________

Do you Smoke?_______ Yes *(Currently)* _______ No *(But I have in the past)* _______ No ***(Never)***

Do you drink alcohol? Yes/No
How often & how much:____
1-7 drink/week *More than 7 drinks/week*

9310 Eastern Ave. Suite 122 Las Vegas, NV 89123 ▪ 10300 W Charleston Blvd #21, Las Vegas, NV 89135
(702) 489-3300 *office* www.TrimBodyMD.com (702) 410-9143 *facsimile*

TRIMBODYM.D.™
WEIGHT LOSS / ANTI-AGING

Patient Name: ______________________ Date: ______________________

PAST MEDICAL HISTORY

Please circle all that apply

ALLERGIES: *food sensitivities, bee stings, seasonal rhinitis:*

CARDIAC ISSUES: *chest pain, hypertension, heart attack (MI), irregular heartbeat (arrhythmia), palpitations, bypass surgery, pace maker, other:*

CIRCULATION ISSUES: *blood clots, DVTs, poor leg circulation, feet swelling, other:*

DIABETES-RELATED ISSUES: *eye problems, kidney problems, neuropathy, other:*

DIGESTIVE ISSUES: *nausea, reflux (GERD), constipation, bloating, diarrhea, peptic ulcers, gluten sensitivity (sprue) gall bladder problems, other:*

EYE ISSUES: *glaucoma, cataracts, other:*

JOINT ISSUES: *osteoarthritis, rheumatoid arthritis, fibromyalgia, osteoporosis, other:*

KIDNEY ISSUES: *kidney stones, urination problems, prostate problems, other:*

LUNG ISSUES: *asthma, COPD, sleep apnea, other:*

NEUROLOGICAL ISSUES: *migraines, stroke, other:*

PSYCHOLOGICAL ISSUES: *anxiety, depression, anorexia, bulimia, alcohol abuse, drug abuse, diagnosed mental illness, other:*

SURGERY: Specify________________________________ Date: __________________
Specify________________________________ Date: __________________

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Patient Name: ______________________________ Date: ________________________

Has any blood relative ever been diagnosed with any of the following medical conditions?

Diabetes Yes / No Who: ____

Glaucoma Yes / No Who: ____

Heart Disease/Stroke Yes / No Who: ____

High Blood Pressure Yes / No Who: ____

Kidney Disease Yes / No Who: ____

Obesity Yes / No Who: ____

Psychiatric Disorder Yes / No Who: ____

Thyroid Problems Yes / No Who: ____

DIET HISTORY

What is the primary reason for your decision to lose weight?
_____Want to look better _____Concerned for my health _____Need to for my job/special event

When did your weight problem start?
_____Childhood After pregnancy _____After menopause _____Came on gradually

Have you ever used any of the following weight loss methods?

Prescription Diet Pills Yes/No List: ____

Natural Supplements Yes/No List: ____

Food Plans Yes/No List: ____

Foods/Drinks dislikes: ____

Foods/Drinks you crave: ____

What time of day or night are you the hungriest? ____

Do you tend to eat more due to stress or when experiencing an emotional upset? Yes/No

TRIMBODYM.D.™
WEIGHT LOSS / ANTI-AGING

________________________________ ________________________
Patient Name: Date:

DESCRIBE YOUR TYPICAL ENERGY LEVEL OVER THE PAST FEW MONTHS:
(check the statement that best applies)

_____I do other activities when not at work but I am usually too tired to exercise

_____I am not usually fatigued and I exercise 1-3 times per week

_____I exercise 4 or more times per week

How many hours of television do you watch each day? ________________________________

Have you ever considered bariatric surgery? Yes/No
(stomach stapling, gastric bypass, gastric band)

How often do you eat out? ____

How much do you spend a week on food? ______________________________________

PLEASE LIST YOUR DAILY FOOD INTAKE:
(PLEASE BE AS SPECIFIC AS POSSIBLE, INCLUDING # OF SODAS, ETC.)

Breakfast: ____

Mid-morning snack: ____

Lunch: ____

Mid-afternoon snack: ____

Dinner: ____

Late Night snack: ____

OTHER HEALTH & WELLNESS CONCERNS
Please check any concerns, procedures or products that may be of interest to you (check all that apply):

_____Botox
_____Excessive Sweating
_____Dermal Fillers (Juvederm, Restalyne)
_____Acne/Acne Scarring
_____Cellulite Reduction/Removal
_____Skin Care Advice/Products
_____Skin Tightening

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Patient Name: ______________________ Date: ______________________

Disclaimers & Waivers

FINANCIAL WAIVER

I understand the TrimBodyMD weight loss and anti-aging program(s) (and affiliated programs) all medications, supplements, cosmetic products & procedures, as well as certain elective injections will **NOT** be billed to an insurance company. I understand I am obligated for all charges incurred for these services, programs, products, and procedures; and payment is due **at the time services are rendered.** **I understand all services, programs, products, and procedures offered and or administered by TrimBodyMD are NONREFUNDABLE and considered FINAL.**

ELECTIVE INJECTIONS

I understand certain injections, such as vitamin injections and/or hormone replacement therapy injections, are considered elective and typically not covered by most insurance providers. Some examples of these elective injections may include, although are not limited to: Vitamin-D, B12, Alpha Lipoic Acid, Biotin, ect. I understand I am responsible for all charges incurred for these elective injections and payment is due at the time services are rendered.

CONTROLLED SUBSTANCES AND PRESCRIPTIONS

Controlled substance medications are closely monitored by various government agencies. Used properly, many medications under this classification can be highly effective for pharmacological therapeutic treatment of a variety of conditions. To ensure these medications are used correctly, I agree to the following:

1. **I understand TrimBodyMD is not a licensed dispensary clinic and therefore cannot sell, dispense, or distribute any medications.** ***(This excludes many of the dietary supplements included within the weight loss and anti-aging programs, such as Vitamin D and Vitamin B12).***
2. I am responsible for my own medication(s) and in the event a prescription or medication is lost, stolen or misplaced, or consumed sooner than directed by the authorized licensed medical professional, that prescription and or medication will not be replaced. TrimBodyMD will require an office visit and additional fees for services are required.
3. I will **NOT** request or accept a duplicate or similar prescription, whether considered a **controlled** substance or not, from another professional medical provider, for the treatment of any condition(s) TrimBodyMD is currently treating.
4. I understand requests for refills for renewals of prescription medications may take up to 72 hours for authorization. Therefore, I understand such requests should be made at least 3 business days in advance.
5. I understand to renew **controlled substance medications** will require an office visit, a fee for services rendered may be required, and such renewals are only made during office hours.
6. **I understand violating ANY of these terms may result in termination of patient care**.
7. As a courtesy, when requested, TrimBodyMD may store an injectable medication as a courtesy to our patients. Shall I request this courtesy, I again, acknowledge, TrimBodyMD is not a license dispensary clinic and the storing of this medication is strictly as a courtesy to me as a patient.

PRIVACY PRACTICES

I have received a copy of the Privacy Practices of this medical facility. I understand these practices can change over time reflecting changes in federal, state, and local laws, which TrimBodyMD extends its best efforts to safeguard Protected Health Information (PHI).

I have read and understand the disclaimers and waivers as stated above:

______________________	______________________	____________
Printed name of patient	*Signature acknowledging above*	*Date Signed*

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Patient Name: ______________________________ Date: ________________________

PRESCRIBED MEDICATIONS & PREFERRED PHARMACY DISCLAIMER

TrimBodyMD offers a variety of medical weight loss and anti-aging programs, which may include prescribed medication(s) from an authorized and licensed practitioner, or medical provider.

TrimBodyMD is not a licensed dispensary of any prescription medications and TrimBodyMD does not sell or distribute any prescription medication(s), of any kind.

TrimBodyMD offers a variety of programs where our preferred pharmacy has approved cash pay rates, and TrimBodyMD incurs, as a courtesy to our patients on our programs.

Patients should be aware any medication(s) prescribed in our medical weight loss and/ or anti-aging programs may be available at a lower cost from another pharmacy of their choice. In the event a patient elects to use another pharmacy, the **price** of the TrimBodyMD medical weight loss and/or anti-aging program does not change; and patient assumes all costs and obligations associated their elected pharmacy.

Please indicate you understand the policy for medication(s) prescribed by a licensed and authorized provider of TrimBodyMD by initialing and signing below:

_______ **I have read and understand the above disclaimer regarding prescribed medication(s) and preferred pharmacy within the TrimBodyMD programs.**

_______ **I understand I can purchase any prescribed medications from another pharmacy of my choice and I am responsible for all costs associated with the prescribed medication(s) at the pharmacy of my choice.**

_______ **I understand using another pharmacy of my choice does not effect the price of the medical weight loss or anti-aging program I purchased from TrimBodyMD.**

______________________________________ ______________________________

Signature of patient Date signed

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