Wellness Weight Management Program

Patient Information (* Required) Date:_____

Name: First: _____ Middle: _____ Last _____

Address: _____City _____State___ Zip_____

Home Phone #_____ Cell Phone # _____

Email Address_____ *Social Security #_____

D.O.B._____ Age: _____ Gender: M F *Driver's License #_____ State: _____

Marital Status: _____ Occupation: _____

Employer: _____ Phone # _____

Emergency Contact: _____ Relation to Patient: _____ Phone #_____

Family Physician: _____ Phone # _____Fax # _____

Preferred Pharmacy: _____ Phone #_____

Do you have diabetes? YES NO If yes, which type? _____

Do you have any food allergies? YES NO If yes, please list them: _____

_____

* What medications are you currently taking? Include Rx name: Dosage: How often: Reason:

1._____
2._____
3._____
4._____
5._____
6._____
7._____

* Do you have any medication allergies? If so, please list and indicate the type of reaction you have.

1._____
2._____
3._____
4._____

How did you hear about us? Post Card, TV, Family, Friend, Social Media, Internet, Doctor, Radio, Clipper, Other_____