BEST WEIGHT MEDICAL
Helping you find your best weight

PLEASE PROVIDE INSURANCE CARD(S) & PHOTO ID OR DRIVERS LICENSE

Today's Date: _____

PATIENT INFORMATION:

Patient's Name: _____
(First Name) (M.I.) (Last Name)
I preferred to be addressed as /my nickname is: _____ Sex: _____
SS #: _____ DOB: _____

Address: _____
(Street Address) (City/State) (Zip Code)

Home Phone: (_____) _____

Cell Phone: (_____) _____

Email: _____

PRIMARY CARE/REFERRING PHYSICIAN INFORMATION:

Did a Physician Refer You? ☐ NO ☐ YES If Yes, Referring Provider Name: _____

Who is your Primary Care Physician: _____

How did you find us? Were you referred by:
Family or friend *(name):* _____ Insurance Plan_____ Internet _____
Other *(please specify)* _____ Prior Patient_____ TV ad_____

DEMOGRAPHICS:

1) **Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasian
☐ Native Hawaiian ☐ Other Race ☐ Decline to Report

2) **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic ☐ Decline to Report

3) **Preferred Notification Method:** ☐ Postal Mail ☐ Phone - Home ☐ Phone - Cell ☐ Email

4) **Marital Status**: ☐ M ☐ S ☐ D ☐ W

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we notify? _____

Relationship to Patient: _____ Phone: (_____) _____

FOR MINORS ONLY: PARENT OR LEGAL GUARDIAN INFORMATION –
Parent or Legal Guardian Name: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell: (____) _____

PATIENT/PRIMARY INSURED EMPLOYMENT INFORMATION

Patient's Employer Name & Address: _____

Employer's Phone **(_____)**_____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Date of Birth:_____

INSURANCE COVERAGE: (we will need to make a copy of your cards – please provide your cards)

Primary Company Name:_____

Subscriber ID#_____Group #:_____

Secondary Company Name:_____

Subscriber ID#_____Group #:_____

DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

☐ Same as Emergency Contact.

☐ I authorize release of medical information to my primary care, referring doctors and consultants.

☐ I authorize you to send me practice related emails.

☐ These are the additional persons I give my permission to disclose information about my medical treatment:

Name: _____Relationship: _____ Phone #: (___) _____

Name: _____Relationship: _____ Phone #: (___) _____

☐ I do **NOT** give permission to disclose personal medical information about my treatment to family members or friends.

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR VOICEMAIL/EMAIL?

☐ **YES** ☐ **NO**

ALL PATIENTS PLEASE READ AND INITIAL/SIGN

I hereby acknowledge that I have been provided with an opportunity to review the privacy notice of health information practices of Best Weight Medical. _____(Initials)

I consent to the use of electronic communication to contact me. This may include, but is not limited to, text messaging, emails to the email address provided above, and real time synchronous video sessions.

_____(Signature)

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

Consent for treatment: I authorize Best Weight Medical, and its agents, to render treatment to me including medical/surgical care___Yes ___No

II. Assignment of Benefits/Release of medical information: I request that payment for authorized Medicare or other applicable private insurance benefits be paid directly to Best Weight Medical for services provided under their care. I also authorize Best Weight Medical to release necessary medical information, including psychological information, to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

Patient/Legal Guardian Signature:_____ Date:_____

Print Name:_____

FOR MEDICARE PATIENTS ONLY

Medicare Authorization: I request that payment for Medicare Benefits be made on my behalf to Best Weight Medical for any services provided to me by its Providers. I authorize Best Weight Medical to release to the CMS and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare benefits apply.

MEDICARE IS NOT ALWAYS THE PRIMARY INSURANCE. FEDERAL REGULATIONS REQUIRE THAT WE OBTAIN INFORMATION TO DETERMINE IF ANOTHER INSURER MAY BE PRIMARY TO MEDICARE:

1. Do you or your spouse currently work for a company, which has 20 or more employees, and have insurance through that employer? ___Yes ___No

2. Are you covered by an HMO/PPO, which makes Medicare secondary? ___Yes ___No

3. Is this illness covered by the VA? ____Yes ____No

4. Is this illness covered by Federal Black Lung or End Stage Renal Disease Program? ____Yes ____No

5. Is this illness/injury due to an automobile accident? ____Yes ____No

6. Is this illness/injury due to work related causes? ____Yes ____No

Patient Signature:_____ Date:_____

A copy of this signature will be used for release of information to your insurance companies and for assignment of benefits Best Weight Medical.

CO-PAYMENT, DEDUCTIBLE AND PAST DUE BALANCES ARE PAYABLE WHEN SERVICES ARE RENDERED: NO EXCEPTIONS PLEASE, THANK YOU!

Request for Release of Medical Information

I hereby authorize: _____

_____

_____

to release copies of all my medical records pertaining to any/all office visits, hospital admissions, tests, procedures, or results for:

Patient Name: _____

Date of Birth: _____

SSN: _____

To be released to: Best Weight Medical
3200 Telegraph Rd.
Ventura, CA 93003
Phone: 805-850-3238 Fax: 530-687-8322

To be used for the purposes of continued medical care.

This consent will expire one (1) year after the date below, or sooner, if I choose to revoke this authorization in writing.

I place no limitations on history of illness, diagnostic and therapeutic information, including any treatment for alcohol/drug abuse, psychiatric disorders or HIV infection.

Date:_____ Signature:_____

Medical History Questionnaire

Patient Name _____ Date of Birth _____

Today's Date _____

Do have any allergies to any medications? Yes No If yes, what medications and reaction?

_____

Do you take medications? Yes No If yes, please list your medications.

_____

_____

What medical problems have you had? Diabetes High Blood Pressure Heart Disease Stroke

High Cholesterol Arthritis Asthma Others? Please list _____

_____

What surgeries have you had? _____

_____

Do you use or have you ever used tobacco? Yes No If yes, give details _____

_____

Do you use or have you ever used alcohol? Yes No If yes, give details _____

_____

Do you use or have you ever used other drugs? Yes No If yes, give details _____

_____

Weight History

Patient Name _____ Date of Birth _____

Today's Date _____

Highest Weight Ever _____

Weight Before Surgery _____ Lowest Weight After Surgery _____

What other methods have you used to try to lose weight? _____

_____

Have you taken medications for weight loss? Yes No If yes, what medications? _____

_____

Circle the ones that you helped you lose weight.

Did you have any side effects to any of the medications? Yes No If yes, list side effects

_____

During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)? Yes No

How many hours do you spend in bed each night? _____

How would you rate your sleep? Excellent Good Fair Poor

On a scale of 1-10, how would you rate your current stress level? _____ /10

What **types** of physical activity (exercise) do you get in a typical week (include work)? _____

_____ How **much** physical activity in a typical week? _____

What do you drink? Water Sodas Alcohol Juices Energy Drinks Coffee Tea _____

Who lives at home with you? _____

Who does the grocery shopping? _____ Who prepares the meals

at your home? _____ How many meals do you eat out each week? _____

How often do you feel out of control when eating? (Circle below)

Less than once a month Once a month Once a week More than once a week

****On the back of this form,**

write down everything you have had to eat or drink in the last 24 hours**