Patient Registration Form

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of injury:

PATIENT'S PERSONAL INFORMATION ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex**: ☐ Male ☐ Female

Name:_____ _____ _____
Last Name First Name Int.

Street Address:_____ (Apt #_____) City:_____ State: _____ Zip:_____

Home Phone:(_____)_____ Work Phone: (_____)_____Cell Phone: (_____)_____

Date of Birth: _____/_____/_____ SSN _____-_____-_____ E-mail: _____

How do you wish to be addressed? _____ Fax #: (____)_____

Employer/Name of School: _____ ☐Full-time ☐Part-Time

Your occupation:_____

PATIENT'S / RESPONSIBLE PARTY INFORMATION

Responsible party:_____ Date of Birth:_____ Age: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other_____ SSN: _____-_____-_____

Responsible party's home phone: (_____)_____ Work phone: (_____)_____

Street Address:_____ (Apt #_____) City:_____ State: _____ Zip:_____

Employer's Name:_____Employer's phone: (_____)_____

Street Address:_____City:_____ State: _____ Zip:_____

PATIENT'S INSURANCE INFORMATION Please present insurance cards to receptionist. ☐ Medicare ☐ Medicaid

PRIMARY insurance company's name: _____

Name of Insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID number:_____ Group number: _____

SECONDARY insurance company's name: _____

Name of Insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID number:_____ Group number: _____

SPOUSE INFORMATION Spouse Name: _____ Spouse SSN: _____-_____-_____

Spouse Date of Birth: _____ Spouse Employer: _____ Work phone #:(_____)_____

Work Address:_____ State: _____ Zip:_____

EMERGENCY CONTACT

Name of person not living with you:_____ Relationship:_____

Street Address:_____ (Apt #_____) City:_____ State: _____ Zip:_____

Home Phone:(_____)_____ Work Phone: (_____)_____Cell Phone: (_____)_____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Cape Family Medical Clinic, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____ Your Signature:_____

Patient Name: _____ Age: _____ Date of Birth: _____

Are you in good health at the present time, to the best of your knowledge? Yes ____ No ____

If "No", explain:_____

_____

Are you under a doctor's care at the present time? Yes ____ No ____

If "Yes", for what? _____

_____

Last Physician Seen: _____

Your Family Medical History (Tell us of your family's medical history to the best of your ability)

	Father	Mother	Brother(s)	Sister(s)	Close Relatives
Age if living?					
General Health?					
Diseases?					
Overweight?					
Cause of Death?					
High Blood Pressure?					
Kidney Disease?					
Heart Disease/Stroke?					

Your Past Medical History Circle Yes or No

Gallbladder Disorder	YES / NO		Jaundice	YES / NO
Nervous Breakdown	YES / NO		Pleurisy	YES / NO
Rheumatic Fever	YES / NO		Tuberculosis	YES / NO
Blood Transfusion	YES / NO		Pneumonia	YES / NO
Whooping Cough	YES / NO		Eating Disorder	YES / NO
Bleeding Disorder	YES / NO		Osteoporosis	YES / NO
Heart Valve Disorder	YES / NO		Thyroid Disease	YES / NO
Psychiatric Illness	YES / NO		Cancer	YES / NO
Kidneys	YES / NO		Tonsillitis	YES / NO
Scarlet Fever	YES / NO		Ulcers	YES / NO
Drug Abuse	YES / NO		Anemia	YES / NO
Arthritis	YES / NO		Gout	YES / NO
Typhoid Fever	YES / NO		Chicken Pox	YES / NO
Liver Disease	YES / NO		Lung Disease	YES / NO
Heart Disease	YES / NO		Alcohol Abuse	YES / NO
Measles	YES / NO		Other	YES / NO

PRACTITIONER SIGNATURE _____ DATE _____

MEDICAL HISTORY

Do you have frequent ear infections? ☐ YES ☐ No
Have you been told you have a hearing loss? ☐ YES ☐ No
Have you had drainage from your ears? ☐ YES ☐ No
Do you have frequent tonsillitis or sore throats? ☐ YES ☐ No

Do you wear glasses and/or contacts? ☐ YES ☐ No
Have you noticed any recent change in your vision? ☐ YES ☐ No
Do you have cataracts or glaucoma? ☐ YES ☐ No
In the past month have you had nausea or vomiting? ☐ YES ☐ No

Do you have any stomach pain? ☐ YES ☐ No
Does any medication upset your stomach? ☐ YES ☐ No
Do you have frequent constipation? ☐ YES ☐ No
Do you have pain when urinating? ☐ YES ☐ No
Have you had kidney stones? ☐ YES ☐ No

Any kidney/bladder infections in the last month? ☐ YES ☐ No
Are you being treated for anemia? ☐ YES ☐ No
Do you have a bleeding problem? ☐ YES ☐ No
Do you have a lymph gland problem? ☐ YES ☐ No

Do you have any chronic lung problems? ☐ YES ☐ No
Have you had a chest infection recently? ☐ YES ☐ No
Have you had any shortness of breath? ☐ YES ☐ No
Have you been treated for asthma? ☐ YES ☐ No

Have you had chest pain? ☐ YES ☐ No
Are you being treated for high blood pressure? ☐ YES ☐ No
Do you have any history of high blood pressure? ☐ YES ☐ No
Have you had phlebitis or blood clots in your legs? ☐ YES ☐ No
Do you have any history of feet swelling? ☐ YES ☐ No
Do you have a history of diabetes? ☐ YES ☐ No
Do you have a history of heart disease? ☐ YES ☐ No

Have you had any serious injuries to your joints? ☐ YES ☐ No
Have you had any broken bones? ☐ YES ☐ No
Are you thirsty more than normal? ☐ YES ☐ No
Do you frequently urinate? ☐ YES ☐ No

Do you have frequent headaches? ☐ YES ☐ No
Have you had seizures? ☐ YES ☐ No
Have you had problems with drugs/alcohol? ☐ YES ☐ No
Have you been treated for depression? ☐ YES ☐ No

Do you have hives? ☐ YES ☐ No
Do you have hay fever? ☐ YES ☐ No
Have you had any numbness or tingling? ☐ YES ☐ No
Have you had any paralysis? ☐ YES ☐ No
Have you recently lost/gained significant weight? ☐ YES ☐ No

Do you have night sweats/chills or fever? ☐ YES ☐ No
Do you have a history of sleep apnea? ☐ YES ☐ No
Have you had skin cancer? ☐ YES ☐ No
Do you bruise easily? ☐ YES ☐ No
Have you been diagnosed with arthritis? ☐ YES ☐ No

Major medical problems? ☐ YES ☐ No
If so, explain: _____
_____
_____

Have you had any major surgeries? ☐ YES ☐ No
If so, list type and date: _____
_____
_____

Have you been hospitalized? ☐ YES ☐ No
Explain: _____
_____

Have you had an injury requiring physician care? ☐ YES ☐ No
Explain: _____
_____

Do you smoke? ☐ YES ☐ No
If yes, how many per day? _____
How many cigars per day? _____
Number of years you have smoked? _____

Do you use other tobacco? _____Snuff
_____Chewing tobacco

Number of years you have used tobacco? _____

When was your last tetanus shot? _____

Are you allergic to any medications? ☐ YES ☐ No
If yes, please list: _____
_____

ARE YOU PREGNANT? _____

Are you taking any medication(s) at the present time? ☐ **YES** ☐ **No**

If yes, please list ALL medications:

Drug: _____	Dosage: _____	Drug: _____	Dosage: _____
Drug: _____	Dosage: _____	Drug: _____	Dosage: _____
Drug: _____	Dosage: _____	Drug: _____	Dosage: _____
Drug: _____	Dosage: _____	Drug: _____	Dosage: _____

Patient's Signature _____ Date _____
Patient's Date of Birth _____
Practitioner's Signature _____ Date _____

Nutritional Evaluation

_____
PATIENT NAME

1. What is the main reason for your decision to lose weight?

_____

2. Desired weight: _____

3. In how many months would you like to be at this weight? _____

4. Weight at 20 years of age? _____ Weight 1 year ago? _____

5. When did you begin gaining excess weight? (give reason(s) if known)

_____

6. What is the most you have weighed (non-pregnant)? _____ When? _____

7. Is your spouse, fiancée or partner overweight? Yes / No
   If "Yes", approximately how much overweight? _____

8. How often per week do you eat out? _____

9. How often per week do you eat "fast food"? _____

10. Foods you are allergic to: _____

11. Foods you strongly dislike: _____

12. Foods you crave: _____

13. Time(s) of day or month you crave food? _____

14. Do you drink coffee or tea? Yes / No
   If "Yes", how much daily? _____

15. Do you wake up hungry during the night? Yes / No
   If "Yes", how often? _____

16. Previous diets you have followed. List name (description) and your results:

_____

_____

_____

_____

17. Do you consume prepared frozen meals? Yes / No
   If so, approximately how many per week? _____

18. Circle how often you use table salt in food preparation (cooking, baking, frying, etc.)

Never Seldom Average Frequently Always

19. Circle how often you use table salt when eating your individual meal

Never Seldom Average Frequently Always

20. How many fruits do you eat each day? _____ Which fruits do you eat mostly? _____

_____

21. How many vegetables do you eat each day? _____ Which vegetables do you eat mostly?

_____

22. How many servings of meat do you consume daily? _____

23. Please circle which meats you primarily eat?

Poultry Fish Beef Pork

24. Please write down all the foods, snacks, and drinks that you have consumed in the last 24 hours.

_____

_____

_____

Lifestyle Considerations

1. Do you drink alcohol? Yes / No

   If "Yes", complete: Daily? Yes / No Weekly? Yes / No Occasionally? Yes / No

2. Tobacco smoking habits: _____

- ☐ Have never smoked
- ☐ Quit smoking _____ years ago and have not smoked since

3. Activity level (choose only 1)

- ☐ Inactive: no regular physical activity with a sit-down job
- ☐ Light activity: no organized physical activity during leisure time
- ☐ Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, etc.
- ☐ Heavy activity: consistent lifting, stair climbing, etc. or regular jogging, swimming, etc. 3 times per week
- ☐ Vigorous activity: extensive physical exercise at least 60 minutes per session, 4 times per week

4. Do you go for casual walks? Yes / No

   If so, how often? _____

   Circle amount of approximate time spent during the walk

   15 min 30 min 45 min 1 hr

5. Do you have any exercise equipment in your home? Yes / No

   Please list: _____

   _____

6. Does anyone in your home own a bicycle? Yes / No

   If so, do you ride it? Yes / No

   How often? Never Seldom Average Frequently

7. When shopping, do you park away from the store so as to increase the walking distance? Yes / No

8. Do you have a friend to exercise with? (Such as walking, bicycling, etc.) Yes / No

9. Do you eat to alleviate boredom? Yes / No

10. Circle approximate leisure time (after work hours) spent daily on the items below:

Watching TV	1 hour	2 hrs.	3 hrs.	4 or more hrs.
Computer/Internet Use	1 hour	2 hrs.	3 hrs.	4 or more hrs.
Electronic Games	1 hour	2 hrs.	3 hrs.	4 or more hrs.

SIGNATURE OF FNP _____ DATE _____

Patient Informed Consent for Appetite Suppressants

Procedure and Alternatives:

1. I _____ (patient or guardian) authorize Robert Daniel Dansby III, FNP and whomever he designates as his assistants to assist me in my weight reduction efforts. I understand my treatment may involve but not be limited to, the use of appetite suppressants for more than 12 weeks and, when indicated, in higher doses than the dose indicated in the appetite suppressant labeling; I understand that my program may consist of a balanced deficit diet, a regular exercise program, instructions in behavior modification techniques, and may involve the use of appetite suppressant medications.

2. I have read and understand my doctorôs statements that follow:
ñMedications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.ò

   ñAs a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and, at times, in increased doses.ò

   ñSuch usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects.ò

   ñAs a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give.ò

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss, in particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressant.

Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat, and heart irregularities. Less common, but more serious risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

Risks Associated With Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

No Guarantee:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

Patient (or guardian) Signature: _____ Date: _____

WARNING:

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THE CONSENT SIGNATURE FORM.

PHYSICIAN'S/ NURSE PRACTIONER'S DECLARATION:

I have explained the contents of this document to the patient and have answered all of the patientôs related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

PATIENT CONSENT FOR APPETITE SUPPRESSANTS &

WEIGHT LOSS PROGRAM:

I have fully read and fully understand this consent form. I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever, concerning the proposed treatment or other possible treatments, ask your Doctor or Nurse Practitioner NOW BEFORE SIGNING this consent form.

CONSENT TO TREATMENT FOR A FEMALE PATIENT:

If you are a female patient you have been notified that **PHENTERMINE** AND OTHER ANORECTIC MEDICATIONS **SHOULD NOT BE TAKEN DURING PREGNANCY, DUE TO THE CHANCE OF DAMAGE TO THE FETUS.** The medications have been explained to me fully and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both this clinic AND my OB/GYN immediately.

BOTH PATIENT AND PRACTITIONER SIGNATURE REQUIRED UPON UNDERSTANDING AND AGREEING WITH ALLTHE INFORMATION THAT IS CONTAINED ON THIS PAGE.

PATIENT'S SIGNATURE: _____ DATE: _____

PRACTITIONER'S SIGNATURE: _____ DATE: _____