Patient Information Form

Patient Name (Last)_______________________________ (First)____________________________________ (MI)________

Name you prefer to be called:____

Patient Address:____

City:____ State________________________________ Zip______________

Phone number you would prefer us to use:____

May we email you? Y/N If yes, email address:____

Birthdate:____ Age:______________________ Sex: M F

Employment Information:

Patient Employer:_____________________________________ Occupation:_______________________________________

Driver's License Number:____ State:____________________________________

In Case of Emergency:

Name:____ Relationship:________________ Phone:_______________

Family Physician:____ Phone:_______________

How did you hear about us? (Please circle one)

Direct Mail Radio Drive-by TV Brochure Internet Yellow Pages Friend

If referred, by whom:____

If you refer another patient, you will receive $10 of your next visit!

Financial Policy:

Thank you for selecting Medi-Slim Weight Loss and Dr. Pamela Gabriel for your weight management needs. We are honored to be of service to you, your family and friends. This is to inform you of our financial policy.

Please read and initial the items below.

____ Payment for all services will be due at the time services are rendered. There will be no exceptions.

For your convenience, we accept Visa, MasterCard, Discover, American Express, Debit Cards, checks and cash.

____ Payment for packages must be completed before treatment has begun.

____ Package treatments must be completed within 6 months of the date of purchase or they will expire.

____ Packages cannot be transferred to another patient or changed to another service.

____ We do not offer refunds.

____ We cannot accept returns of any food items.

____ If a patient is to return after being absent for 1 year, the full new patient price will be applicable.

I have read and understand all of the above and have agreed to these statements.

____ ____

Patient Signature Date

Weight Loss Program Consent Form

I, ____ authorize Dr. Pamela Gabriel and whomever she designates as her assistant, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplement diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. I understand that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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 to me. My questions have been answered to my complete satisfaction. I 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 now before signing this consent form.

______________________________________ ______________________________________
Patient or guardian Date

____
Office Staff

Patient Informed Consent for Appetite Suppressants

I. Procedures and Alternatives

1. I, ____ authorize Dr. Pamela Gabriel and 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.

2. I have read and understand my doctor's statements that follow:

" Medications, including appetite suppressants, have labeling worked out between the makers of the medication and the FDA. 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.

"As 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 suggest, 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.

"Such 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 (as noted below).

"As 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."

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 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 exchanged 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 suppressants.

II. 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 vascular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. 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.

IV. No Guarantees:

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.

V. Patient's Consent:

I have read and fully understand this consent form and I realize and 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 regarding 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.

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, please ask now before signing this consent form.

____ ____________________ ___________________
Patient Signature Date Time

____
Witness

VI. Physician Declaration

I have explained the contents of this document to the patient and have answered all the patient's 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.

____
Physician Signature

Patient Medical History Form

Patient Name:____

Present Status:

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

If No, Please explain

____

____

____

2. Are you under a doctor's care at the present time for any reason? Yes No

If yes, for what reason(s)?

____

____

____

3. Are you taking medications (prescription, over-the-counter, herbal or vitamins) at the present time? Yes No

Medication **Dosage**

____

____

____

____

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____

____

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____

____

Any Allergies to Any Medications? Yes No

Specify:____

____

____

____

Patient Medical History Form

Past Medical History: (Circle all that apply)

Polio	Measles	Tonsillitis
Jaundice	Mumps	Pleurisy
Kidney Disease	Scarlet Fever	Liver Disease
Lung Disease	Whooping Cough	Chicken Pox
Rheumatic Fever	Bleeding Disorder	Nervous Breakdown
Ulcers	Gout	Thyroid Disease
Anemia	Heart Valve Disorder	Heart Disease
Tuberculosis	Gallbladder Disorder	Psychiatric Illness
Drug Abuse	Eating Disorder	Alcohol Abuse
Pneumonia	Malaria	Typhoid Fever
Cancer	Blood Transfusion	Arthritis
Osteoporosis	Heart Attack	Illegal Drug Use
Diabetes	High Blood Pressure	Drug Dependence

Other:____

Serious Injuries: (Only if it effects ability to exercise) Yes No

____

____

Any Major Surgery Yes No

____

____

History of Sleep Apnea Yes No

Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father					
Mother					
Brothers					
Sisters					