United Doctors

REGISTRATION FORM FOR WEIGHT LOSS PROGRAM

PATIENT INFORMATION			
Today's Date:			**Date of Birth:**
Last Name:	**First:**	**Middle:**	**Gender at Birth:** ❑ Male ❑Female ❑Unknown
Street Address:			**Cellular Phone Number:** ( )
City:	**State:**	**Zip Code:**	**Other Phone Number:** ( )
E-Mail Address:			**If Under 18, Parent/Guardian's Name:**

Sexual Orientation: ❑ Lesbian/ Gay ❑ Heterosexual (or straight) ❑ Bisexual ❑ Something else ❑ Don't know ❑Choose not to disclose	**Gender Identity:** ❑ Female ❑ Male ❑ Transgender (Female-to-Male) ❑ Transgender (Male-to-Female) ❑ Other ❑ Choose not to disclose

How Did You Hear About The Health Center? ❑ Family ❑ Friend ❑ Flyer ❑ Center Staff ❑ Internet ❑ Hospital ❑ Other: _____

EMERGENCY CONTACT [IN CASE OF EMERGENCY, PERSON WE MAY CONTACT]

FIRST AND LAST NAME:_____ **PHONE NUMBER:**_____

RELATIONSHIP TO PATIENT: ❑ Spouse ❑ Child ❑ Parent ❑ Other: _____

I grant the above person permission(s) to: ❑ share medical information ❑ make medical decisions ❑ renew medications ❑ discuss my billing account

PATIENT DEMOGRAPHICS (PLEASE ANSWER ALL QUESTIONS)

Ethnicity: ❑ Hispanic/Latina(o) ❑ Non-Hispanic/Latina(o) ❑ Prefer not to Report

Race: ❑ Black ❑ White ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ More than one race ❑ Prefer not to Report

Marital Status? ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Employed? ❑ Yes ❑ No	**Occupation:**

MEDICAL HISTORY

MEDICATIONS - ***Please List all Medications you are currently taking:***

Medication	Dosage	How is Taken	Frequency

United Doctors

REGISTRATION FORM FOR WEIGHT LOSS PROGRAM

ALLERGIES - *Please List all Allergies:*		
Allergies	**Allergies**	**Allergies**

PAST MEDICAL HISTORY - *Do you now or have you ever had:*		
☐ Diabetes	☐ Heart Disease	☐ Stroke
☐ High Blood Pressure	☐ Kidney Disease	☐ Hepatitis
☐ High Cholesterol	☐ Pulmonary Embolism	☐ HIV/AIDS
☐ Hypothyroidism	☐ Gallbladder disease	☐ Epilepsy (seizures)
☐ Hyperthyroidism	☐ Pancreatitis	☐ Hepatitis
☐ Depression or Anxiety	☐ Meduallry thyroid cancer (you or family member)	☐ Stomach or Peptic Ulcer (GERD)
☐ Sleep Apnea	☐ PCOS	☐ Eating disorder
☐ Cancer (type)	☐ Multiple Endocrine Neoplasia (MEN)	☐ Other illness:

SURGICAL HISTORY - *Please list any surgeries you have had including the year and month:*		
Surgeries	**Month**	**Year**

FAMILY HISTORY - *Please list your Family History:*				
	If Living	**If Living**	**If Deceased**	**If Deceased**
	Age (s)	**Health & Psychiatric**	**Age(s) at Death**	**Cause**
Father				
Mother				
Siblings				

SOCIAL HISTORY - *Do you use*		
Tobacco ☐ YES ☐ NO	**Alcohol ☐ YES ☐ NO**	**Recreational Drugs ☐ YES ☐ NO**

United Doctors

REGISTRATION FORM FOR WEIGHT LOSS PROGRAM

LIFESTYLE AND GOALS		
1	Are you currently pregnant or breastfeeding? ☐ **YES** ☐ **NO** ☐ **N/A**	
2	What is your current weight in _____lbs	Height: _____ feet _____ inches
3	Desired weight loss goal _____ lbs	Previous weight loss attempts ☐ **YES** ☐ **NO**
4	What has worked or not worked for you in the past?	
5	What do you consider to be your ideal weight?	
6	What is the hardest part about managing your weight?	
7	What's more important inches lost or pounds?	
8	Do you binge eat? ☐ **YES** ☐ **NO**	
9	Do you suffer from uncontrollable cravings? ☐ **YES** ☐ **NO**	
10	Do you feel the food controls you? ☐ **YES** ☐ **NO**	
11	Do you eat between meals? ☐ **YES** ☐ **NO**	
12	**Exercise:** Do you regularly exercise? ☐ **YES** ☐ **NO**	
13	If yes how many times per week? ☐ **2-3 times** ☐ **>4 times** ☐ **Occasionally** ☐ **Never**	
14	**Sleep:** Average hours of sleep at night _____	Dou you have Insomnia? ☐ **YES** ☐ **NO**
15	Are you comfortable using weekly injections for weight loss ? ☐ **YES** ☐ **NO** ☐ **N/A**	
16	**Commitment to weight loss** (please rate): (low) **1 2 3 4 5 6 7 8 9 10** (high)	

PATIENT CONSENT FOR TREATMENT

By signing below, I, or my authorized representative), consent to the providers and staff of United Doctors ("the Center") performing diagnostic examinations, tests, and procedures as deemed necessary to assess, diagnose, and treat my condition. I also authorize the administration of any medications, therapies, or treatments that are medically appropriate for maintaining and improving my health.

I acknowledge and understand the following:

1. **Cash-Based Services**
   I understand that all **weight loss and wellness services** provided at this Center, including consultations, follow-up visits, nutritional counseling, body composition assessments, and prescription or administration of weight loss medications (including compounded or FDA-approved GLP-1 therapies), are **cash-based** and **not billed to insurance**. I am **personally and fully responsible** for all charges incurred at the time of service.

2. **Compounded Medications**
   I understand that certain medications used in my treatment may be **compounded** and are **not approved by the U.S. Food and Drug Administration (FDA)**. These medications are, however, obtained from **licensed 503A and/or 503B pharmacies** that comply with applicable regulations.

3. **Risks, Benefits, and Results**
   I understand that participation in a weight loss or wellness program involves potential **risks and benefits**, and that **results will vary** based on individual factors. There are **no guaranteed outcomes**. I agree to follow all instructions and recommendations provided by the medical staff and to promptly report any adverse effects, side effects, or other concerns.

4. **Nature of Treatment**
   I understand that some treatments provided may **not be considered medically necessary** but are offered to improve overall **quality of life**, wellness, and weight management through medical evaluation, nutritional guidance, and lifestyle support.

5. **Refund Policy**
   I understand that **all services and products rendered are non-refundable**, regardless of treatment outcome.

6. **Follow-Up and Compliance**
   I understand that it is my responsibility to **maintain all scheduled follow-up appointments** as recommended for safe and effective care.

7. **Right to Refuse Treatment**
   I understand that by providing my general consent to treatment, I **retain the right to refuse** any specific examination, test, procedure, treatment, therapy, or medication recommended by my healthcare provider

8. **Cancellation and No-Show Policy**
   I understand that missed appointments or cancellations made with less than 24 hours' notice may result in a **cancellation or no-show fee**. Repeated missed appointments may affect my ability to schedule future visits.

9. **Release and Exchange of Information**
   I authorize United Doctors and its providers to release or exchange my medical information, as permitted by **state and federal law**, for purposes of treatment, care coordination, and practice operations. This may include communication with other healthcare providers, pharmacies, or laboratories involved in my care. I understand that my records will be handled in accordance with the **Health Insurance Portability and Accountability Act (HIPAA)** and applicable **state privacy regulations**, and that I may revoke this authorization in writing at any time, except to the extent that information has already been released.

10. **Telehealth Services:** I understand that follow-up visits, consultations, and certain components of the weight loss program may be provided through telehealth (virtual visits) when appropriate and in compliance with applicable state laws and regulations.

11. **Acknowledgment and Understanding**
    I acknowledge that I have **read and fully understand** this consent form. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

Signature: _____

Patient/Parent/Legal Guardian Signature Date