VITALITY HEALTH

302-643-2500

WEIGHT LOSS PATIENT INFORMATION		
Name		Date of Birth
Address:		City:
State / Zip		
Cell Phone		Addl Phone
Email Address (Required to access patient portal)		
Gender	Female Male	Married Single Widowed Divorced
Ethnicity	Not Hispanic or Latino Hispanic or Latino	
Race	White Black or African American Native American Asian Other	
PREFERRED PHARMACY		
Pharmacy Name		Phone:
Pharmacy Address		
INSURANCE INFORMATION		
Insurance Co Name		
Policy No		GROUP:
SECONDARY INSURANCE		
Insurance Co Name		
Policy		Group No
Guarantor Name		Date of Birth
EMERGENCY CONTACT		
Cell Phone		
PRIMARY PHYSICIAN INFORMATION		
Name		
Address/Phone		

How did you hear about us? _____

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Name _____ Date of Birth _____

Current Weight _____

Desired Weight _____

Previous weight loss attempts: _____

Do you track calories? Yes No

Do you exercise? Yes No If yes, how many times a week ? _____

How long is each exercise session? _____

Do you track calories burned? _____

Biggest barrier to weight loss? _____-

Do you drink soda? Yes No If yes, how much? _____

Do you drink: Beer Wine Liquor

Recent EKG _____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS & DOSAGES. INCLUDE BIRTH CONTROL PILLS, OVER-THE-COUNTER MEDICINES, HERBALS, AND VITAMINS.

Medication	Dosage	How Often	Perscribed By? And for what reason

ADULT PERSONAL HEALTH HISTORY

HAVE YOU BEEN DIAGNOSED WITH THE FOLLOWING:

	Diabetes		Arthritis		Anxiety
	Hypothyroidism		Osteoporosis		Bipolar
	High Blood Pressure		COPD		Cancer
	High Cholesterol		Asthma		Kidney disease
	Stroke		Lupus		Liver disease (Hepatitis)
	Heart attack		Migraines		
	Heart Arrhythmia (Afib)		Seizures		
	Blood clots (Leg, Arm, Lung)		Depression		

DO YOU HAVE ANY **ALLERGIES TO ANY MEDICATION**?

MEDICATIONS	REACTION

DO YOU HAVE ANY ALLERGIES _____

SURGICAL HISTORY (Check all that apply)

☐ I HAVE NEVER HAD SURGERY

DATE	REASON FOR SURGERY

FAMILY HISTORY

☐ NO SIGNIFICANT FAMILY HISTORY

☐ I WAS ADOPTED

CHECK AND LIST FAMILY MEMBERS (MOTHER, FATHER, BROTHER, SISTER AND PLEASE SPECIFY PATERNAL OR MATERNAL AUNT, GRANDMOTHER OR GRANDFATHER) HAD THE FOLLOWING:

Family Member	**Alive /Deceased**	**Age/Age at death**	**Illness**
Father			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Mother			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Siblings			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Children			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke

SOCIAL HISTORY

ARE YOU SEXUALLY ACTIVE? ☐ YES ☐ NO ☐ MEN ☐ WOMEN ☐ BOTH ☐ PREVIOUSLY NOT NOW
DO YOU SMOKE ☐ NO ☐ FORMER ☐ CURRENT SMOKER HOW MANY CIG/DAY_____ FOR _____ YEARS

HAVE YOU USED ANY IN THE LAST YEAR? ☐ MARIJUANA ☐ HEROIN ☐ COCAINE ☐ OTHER	DO YOU USE ANY OTHER SUBSTANCES? ☐ YES ☐ NO IF YES, WHAT TYPE _____ _____

HEALTH SCREENINGS

HAVE YOU EVER HAD A BONE DENSITY? ☐ YES ☐ NO MONTH/YEAR OF LAST BONE DENSITY TEST? _____ RESULT ☐ NORMAL ☐ ABNORMAL IF ABNORMAL, PLEASE EXPLAIN _____	HAVE YOU EVER HAD A COLONSCOPY? ☐ YES ☐ NO MONTH/YEAR OF LAST COLONSCOPY TEST? _____ RESULT ☐ NORMAL ☐ ABNORMAL IF ABNORMAL, PLEASE EXPLAIN _____
HAVE YOU EVER HAD A DIABETES TEST? ☐ YES ☐ NO MONTH/YEAR OF LAST DIABETES TEST? _____ RESULT ☐ NORMAL ☐ ABNORMAL IF ABNORMAL, PLEASE EXPLAIN _____	HAVE YOU EVER HAD A CHOLESTEROL TEST? ☐ YES ☐ NO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE & CONSENT TO USE & DISCLOSE HEALTH INFORMATION

This acknowledgment of notice and consent authorizes Women's Wellness Center to use and disclose health information about you for treatment, payment, and health care operations purposes. Notice of Privacy Practices: Women's Wellness Center has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change.

Acknowledgment and Consent: I have received the Notice of Privacy Practices for Women's Wellness Center. Women's Wellness Center is authorized to use and disclose health information about me too (i.e., spouse, parent, primary physician):

Signature of Patient/Patient Representative

X_____ Date _____

COMMUNICATIONS & MESSAGES

LEAVING MESSAGES

I authorize messages, to include all lab/imaging results and appointment reminders be left at this phone number: Please make sure your voicemail is available so that we can contact you.

PHONE NUMBER: _____

SENDING TEXT MESSAGES

I authorize messages, to include all lab/imaging results and appointment reminders and office announcements be **sent via text** at this cell phone number:

CELL PHONE NUMBER: _____

Signature of Patient/Patient Representative

_____ Date _____

PERSCRIPTION REFILLS

Please allow 5-7 business days to refill any current prescription that does not require prior authorization

PAYMENT POLICY

1. Your medical insurance card and personal identification must be presented to the receptionist at each visit. Medical insurance cards are needed for ordering lab work if you are using insurance to pay for the lab work.

5. We require payment in full on the date of service

X_____ Date _____

Signature of Patient/Patient Representative

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HIPPA FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. The implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HiPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharIng Of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information that is not already a matter of public record, The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room. etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to offIce policy and new technology that you might find valuable or informative

3 The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies Or insurance payers in normal performance of their duties

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6 Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7 We agree to provide patients with access to their records in accordance with state and federal laws.

8 We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I DO HEREBY CONSENT AND ACKNOWLEDGE MY AGREEMENT TO THE TERMS SET FORTH IN THE HIPPA INFORMATION FORM AND ANY SUBSEQUENT CHANGES IN THE OFFICE POLICY. I UNDERSTAND THAT THIS CONSENT SHALL REMAIN IN FORCE FROM THIS TIME FORWARD.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM

PRINT NAME _____

SIGNATURE _____