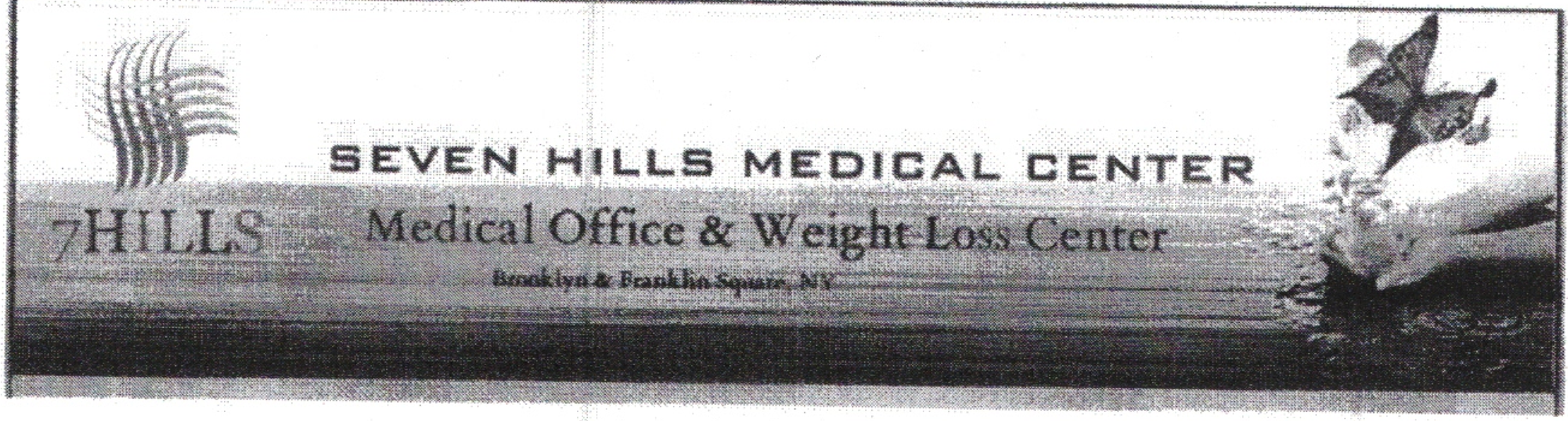


CONSULTATION FEE DISCLAIMER

I, ____ completely agree to pay the initial consultation fee of $99/$49/$39.

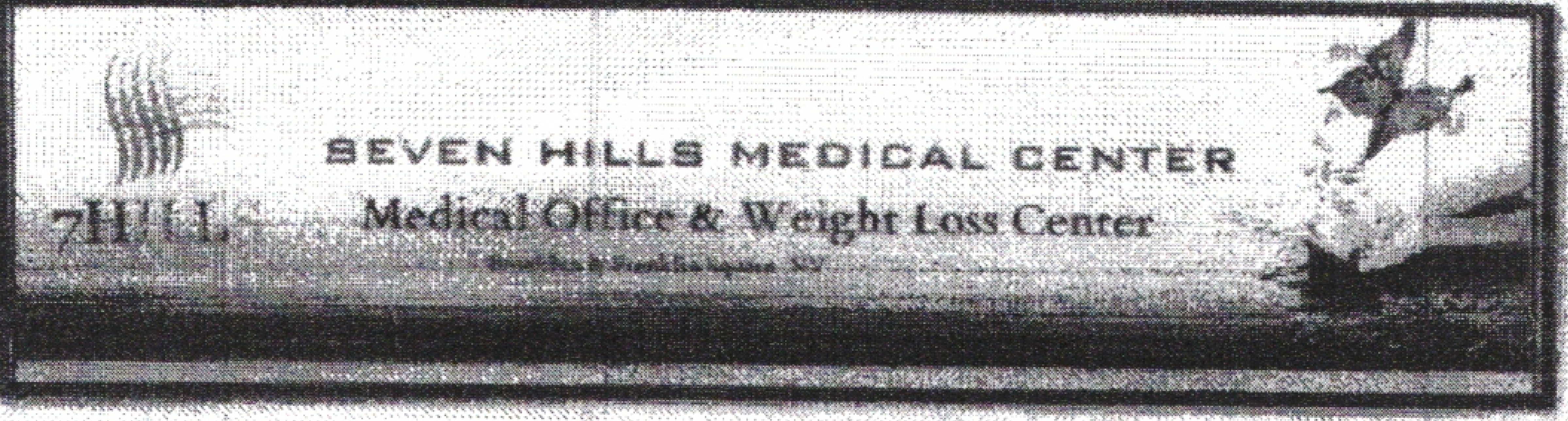
_______ I understand this consult is CASH ONLY and not part of insurance or the Weight Loss Program.

_______ I acknowledge this was explained in detail to me.

______________________________ Signature

______________________________ Date

______________________________ Print Name



Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare beneficiary, to make payments to Seven Hills Medical Services PC/Franklin Medical Care PC for medical or surgical services or items rendered to me or my dependent by Seven Hills Medical Services PC/Franklin Medical Care PC. Should my insurance carrier deny Seven Hills Medical Services PC/Franklin Medical Care PC payment, I understand that I am financially responsible for the charges. I authorize Seven Hills Medical Services PC/Franklin Medical Care PC to release any and all of my records to my insurer or any other third party payer, legally responsible for the payment of medical expenses. It is my responsibility to update any and all personal, insurance, and health information.

I also authorize Seven Hills Medical Services PC/Franklin Medical Care PC to use my email/cell phone for any electronic communications about my appointment dates, results, reminders, etc.

Name (print): ______________________________

Signature: ______________________________

Date: ________________

Email: ______________________________

Phone Number: (______) ________________

Name: ____________________ DOB: ___/___/___

Allergies to Medications, X-Ray Dyes, or Other Substances: [ ] No [ ] Yes

If yes, please list name of medicine and type of reaction:

______________ ______________ ______________ ______________
______________ ______________ ______________ ______________
______________ ______________ ______________ ______________

Past Medical History:

1. High Blood Pressure	13. Bronchitis	25. Ulcers	37. Arthritis
2. Diabetes	14. Pneumonia	26. Change in Bowels	38. Lower Back Problems
3. Cancer	15. Persistent Cough	27. Unexpected Weight Gain/Loss	39. Skin Disease
4. Heart Disease	16. T.B.	28. Hemorrhoids	40. Blood Disorder
5. Chest Pain/Chest Tightness	17. Hay Fever	29. Gall Bladder Disease	41. Venereal Disease
6. Shortness of Breath	18. Abdominal Discomfort	30. Colitis	42. Anxiety
7. Swollen Ankles	19. Indigestion	31. Hepatitis/Jaundice	43. Depression
8. Palpitations	20. Nausea	32. Thyroid Disease	44. Anemia
9. Light Headedness	21. Vomitting	33. Headaches	45. Alcohol Abuse
10. Frequent Urination	22. Constipation	34. Head/Neck Radiation	46. Drug Abuse
11. High Cholesterol	23. Diarrhea	35. Kidney Disease/Stones	47. Gout
12. Asthma	24. Blood in Stool	36. Difficulty Urination	48. Other: ________

Gynecologic and Obstetric History

Onset Period Age: __________ Frequency: __________ Length of Periods: __________

Pregnancies: ________ Births: ________ Miscarriages: ________

Prolonged/Abnormal Bleeding: [ ] No [ ] Yes; If yes, please describe: ______________________

Leakage of Urine: [ ] No [ ] Yes; If yes, please describe: ______________________

Pelvic Pain: [ ] No [ ] Yes; If yes, please describe: ______________________

Abnormal Discharge: [ ] No [ ] Yes; If yes, please describe: ______________________

Please List and Supply Dates of:

Operations: ______________ ______________ ______________
______________ ______________ ______________

Hospitalizations (Other than Surgery): ______________ ______________
______________ ______________ ______________

Name: ________________ **DOB:** ___/___/___

Immunization History

Hepatitis B? [ ] No [ ] Yes If yes, what date? ____________

Pneumovax Immunization? [ ] No [ ] Yes If yes, what date? ____________

Flu Immunization? [ ] No [ ] Yes If yes, what date? ____________

Tetanus Immunization? [ ] No [ ] Yes If yes, what date? ____________

When was Your Last:

Pap Smear? ________ Breast Exam? ________ Mammogram? ________

Prostate Check? ________ Check for Bloody Stool? ________ Cholesterol Check? ________

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	*Family Member*	*Age Approx. Diagnosed*
Cancer (Type)		
Hypertension		
Heart Disease		
Diabetes		
Strokes		
Mental Disease		
Drug/Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other:		

Medications

Drug Name	**Dosage**	**Drug Name**	**Dosage**

Name: ______________________ **DOB:** ___/___/___

Prevention

Do you wear seatbelts? [ ] No [ ] Yes If no, why not? ______________________

Do you wear a bike helmet? [ ] No [ ] Yes [ ] N/A

Do you smoke? [ ] No [ ] Yes If yes, how many per day? ______________________

Do you drink alcoholic beverages? [ ] No [ ] Yes If yes, how many per week? ______________________

Do you use drugs (marijuana, cocaine, heroin, etc.)? [ ] No [ ] Yes If yes, what kind? ______________________

Do you drink coffee? [ ] No [ ] Yes If yes, how many cups per day? ______________________

Do you drink tea? [ ] No [ ] Yes If yes, how many cups per day? ______________________

If there's a gun in your home, do you keep it unloaded & out of children's reach? [ ] No [ ] Yes [ ] N/A

Have you ever engaged in any activity which has put you at risk of getting AIDS? [ ] No [ ] Yes [ ] N/A

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? [ ] No [ ] Yes

Are you in a relationship in which you have been physically hurt by your partner? [ ] No [ ] Yes

Do you ever feel afraid of your partner? [ ] No [ ] Yes

Do you have a living will? [ ] No [ ] Yes

Do you have a donor card? [ ] No [ ] Yes

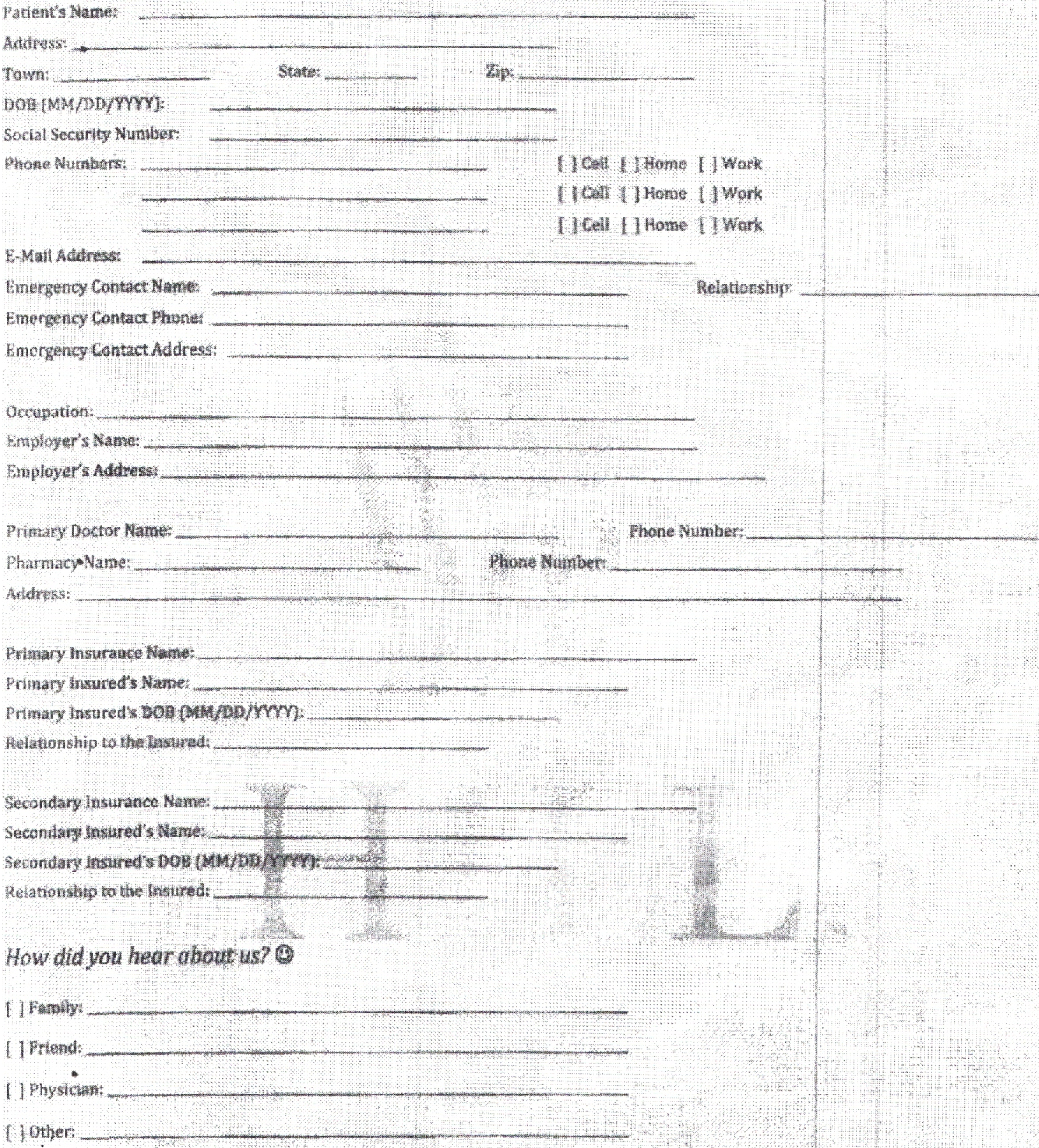
Method of birth control? ______________________

I hereby agree that all the information provided above is accurate to the best of my knowledge.

____
Print Name

______________________ ______________________
Signature Date

Seven Hills Medical Center
Demographics Sheet



Patient's Name: ____________________

Address: ____________________

Town: __________ State: __________ Zip: __________

DOB (MM/DD/YYYY): ____________________

Social Security Number: ____________________

Phone Numbers: ____________________ [ ] Cell [ ] Home [ ] Work

____________________ [ ] Cell [ ] Home [ ] Work

____________________ [ ] Cell [ ] Home [ ] Work

E-Mail Address: ____________________

Emergency Contact Name: ____________________ Relationship: __________

Emergency Contact Phone: ____________________

Emergency Contact Address: ____________________

Occupation: ____________________

Employer's Name: ____________________

Employer's Address: ____________________

Primary Doctor Name: ____________________ Phone Number: __________

Pharmacy Name: ____________________ Phone Number: __________

Address: ____________________

Primary Insurance Name: ____________________

Primary Insured's Name: ____________________

Primary Insured's DOB (MM/DD/YYYY): ____________________

Relationship to the Insured: ____________________

Secondary Insurance Name: ____________________

Secondary Insured's Name: ____________________

Secondary Insured's DOB (MM/DD/YYYY): ____________________

Relationship to the Insured: ____________________

How did you hear about us? ☺

[ ] Family: ____________________

[ ] Friend: ____________________

[ ] Physician: ____________________

[ ] Other: ____________________

Weight Control Expectations Questionnaire

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely and honestly as possible and then reviewing it with your physician, you will learn what can reasonably be expected to occur.

How did you hear about us?

____

How much weight do you expect to lose? __________ Per week __________ Per month __________

What would happen if you do not lose that much or that fast? How will you react?

____

If your weight loss slows down markedly or even completely stops for a while, will you understand the difference between fat loss and water loss? ______________________________

What do you expect from us (your medical counselors)? Be specific. ______________________________

____

____

Will it change your life in any way (for better or worse) when you reach your goal weight? __________

____

____

Do you expect to be doing anything you are not doing now? Describe in detail. __________

____

____

Do you expect to STOP doing something you are doing NOW? Describe in detail. __________

____

____

Will you be able to handle compliments about how you look when you are of normal size? __________

Will your "new normal weight" self pose a threat to your relationship with your significant other? Be specific. _____

____

the center for medical weight loss

How will family and friends respond to the "new you"? ______________________________

____

Do you expect to get a better job? ______________________________

Will you get more respect from other people? Who specifically? ______________________________

____

Will you feel comfortable with these altered responses from others? ______________________________

Will you be expected to perform better at work (or at home)? ______________________________

Will you be more sociable than you are now? ______________________________

Will you have to assume any new responsibilities? Describe in detail. ______________________________

____

What will happen if some of your expectations don't come true? What might you do? ______________________________

____

____

What do you expect to have to do to maintain weight the same? ______________________________

____

Will you continue to watch your food intake? __________ Exercise? __________

Contioue with professional medical monitoring? __________ For about how long? __________

Do you have any other expectation than those listed above? Please describe in detail. ______________________________

____

____

____

Patient Name: ______________________________ DOB: ______________

Email Address: ______________________________ Date: ______________

·MY TYPICAL DAY

TO KNOW YOUR DAILY ROUTINE

I wake up at ____________________AM/PM

My breakfast (First meal after You wake up) at ________________Am/PM

Break Fast Includes and Varies

Any snacks in between_____________________

Next meal of the day : LUNCH at what time and Includes____________________

Any Snacks in Between________________________________

Dinner at :

WATER : How many glasses or bottles per day?____________________

Exercise per day

Name: ______________________________

Please take a moment to fill the following:

I am Grateful:

____
____
____
____
____
____
____
____
____
____

I Appreciate 3 things:

____
____
____

Dr. Thirumalesh Venkatesh