Patient Information Form

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____

Birthdate: _____Age: _____Sex: M F

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cellular:_____

How did you hear about Soboba Medical Group?

Internet Search (Google/Yahoo/MSN/Other) Coupon Mailer Other:_____

Referral From Friend/Co-Worker:_____

Would you like to receive promotional information and special discounts from Soboba?: Yes No

If you would like to receive promotional information and special discounts via email, please write your Email Address:_____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____Ext. _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Financial Policy:

Thank you for selecting our Clinic for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard American Express, Discover, and checks.
I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.
I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date

Patient Informed Consent

I. Procedure And Alternatives:

1. I,_____ (patient or patient's guardian) authorize Soboba Medical Group, Inc. 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. Initial:_____ I have read and understand my doctor's statements that follow:

> "Medications, 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.
>
> "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 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.
>
> "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. Initial:_____ 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. Initial:_____ I understand that **HCG** is an approved medication, but not for weight loss, and it may or may not help me with my weight loss.

5. Initial:_____ 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 suppressants.

II. Risks of Proposed Treatment:

Initial:_____ 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.

Initial:_____ I have read the risks associated with treatment and certify that I have **disclosed all medications and supplements that I am currently taking and all known allergies to food and medications.**

III. Risks Associated with Being Overweight or Obese:

Initial:_____ 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:

Initial:_____ 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:

Initial:_____ 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.

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 THIS CONSENT FORM.

DATE:_____ TIME:_____

PATIENT:_____WITNESS:_____
(or person with authority to consent for patient)

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's Signature

Soboba Medical Group

Medical History Form

Date: _____

Name: _____Age: _____ Sex: M F

Family Physician: _____Phone: _____

Present Status:

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

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

If yes, for what? _____

Are you taking any medications at the present time? Yes No

What: _____ Dosages: _____

What: _____Dosages: _____

Nutrition Evaluation:

Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

In what time frame would you like to be at your desired weight? _____

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

When did you begin gaining excess weight? (Give reasons, if known): _____

_____

Previous diets you have followed:

_____

_____

Give dates and results of your weight loss:

_____

_____