PATIENT INFORMATION SHEET

DATE: _____

NAME:_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SEX (CIRCLE): M OR F

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

SS#: _____

ADDITIONAL INFORMATION:

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY:

_____

PHONE: _____

REFERRED BY: _____

I UNDERSTAND THAT PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT hCG WEIGHT LOSS CLINIC, LLC DOES NOT BILL INSURANCE COMPANIES AND THEREFORE, I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES

_____

Patient Signature