REGISTRATION
(PLEASE PRINT)

Lifestyle Solutions MedSpa

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Website: www.lsmedspa.com Email: info@lsmedspa.com

Date________________

Home Phone: __________________ Cell Phone: ____________________ Email: ________________________________

Patient____
Last Name First Name Initial

Responsible Party (if a minor) ____ Social Security # __________________________

Address: ____ City: _________________ State: _____ Zip: _________

Sex ☐ M ☐ F Age______ Birthdate__________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By____ Business Phone________________________________

Business Address____ Occupation__________________________

Spouse (or responsible party) Name_________________________ Birthdate: ______________ Spouse's SSN: _________________

Business Name and Address ____
Occupation____ Business Phone ______________________ Ext. ___________

Who is responsible for this account? _____________________________ Relationship to Patient _______________

Do you have Medical Insurance? ☐ No ☐ Yes ► If yes,
Name of Primary Insurer: ____
Contract #___________________ Group #_________________ Subscriber #________________
Name of Secondary Insurer (if any) ____
Contract #___________________ Group #_________________ Subscriber #________________

In case of emergency, who should be notified? ______________________________ Relationship: ____________Phone______________

How did you learn about our practice? ____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance converge with____ and assign
Name of Insurance Company
directly to Dr.____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ________________________________
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ___________________________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ________________________________
Beneficiary Signature Date

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HEALTH HISTORY

(Confidential)

Name____ Today's Date________________

Age______________ Birth date________________ Date of last physical examination________________

What is your reason for visit? ____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Other:
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTRIONTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period __________

Date of last Pap Smear___________

Have you had a mammogram? __________

Are you pregnant? ________

Number of Children ________

CONDITIONS Check (✓) conditions you have or have had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

____

____

____

____

Pharmacy ____________________ Phone______________

ALLERGIES To medications or substances

(All Information is strictly confidential)

FAMILY HISTORY: Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	[illegible]	[illegible]	Complications if any

Have you ever had a blood transfusion? ☐Yes ☐No
If yes, please give approximate dates.____________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS: Check which [illegible] and describe how [illegible]

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS: Check if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, even have a change in health.

____
Signature of Patient (Guardian or Personal Representative)

____
Date

____
Print Name of Patient (Guardian or Personal Representative)

____
Relationship to Patient

____
Reviewed By

____
Date

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1. Procedures and Alternatives.
    a. I understand that is my responsibility to follow my physician's instructions carefully and to report any medical problems immediately, regardless of whether I think that they may be related to my weight control program. I further affirm that I am not now pregnant and will report any pregnancy to my physician immediately.
    b. I understand that there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain any weight loss. In particular, a balanced diet combined with physical exercises recommended, with or without the use of appetite suppressants. I understand that a program including a revised diet and physical exercise would prove successful without appetite suppressants if I followed it, even though I would probably be hungrier that if I used appetite suppressants.

2. Risks of Proposed Treatment
    a. I understand that this authorization is given to me with the knowledge that the use of appetite suppressants poses various risks, including but not limited to, pulmonary hypertension, nervousness, sleeplessness, headaches, dry mouth, weakness, fatigue, psychological problems, medical allergies, high blood pressure, rapid heart beat, and heart irregularities. These and other possible risks could occasionally be serous or even fatal.

3. Risks Associated With Being Overweight or Obese
    a. I understand that remaining overweight or obese poses certain risks, among them being tendencies to high blood pressure, to diabetes, to heart attack and heart disease, to arthritis at the joints, hips, knees and feet, and to certain cancers. I understand that these may be modest if I am not very overweight, but that these risk increase significantly with any weight gain.

4. No Guarantees
    a. I understand that much of the success of this program will depend on my efforts. Not with standing my efforts, I understand 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 my life if I am to be successful.

5. Patient's Consent
    a. I have read and fully understand this consent form, the attached Weight Loss Consumers Bill of Rights, and I have had all concerns addressed. Moreover, I have been informed by the information in item (3) above of the mature, risks, possible alternative treatments, possible consequences and possible complications involved in the use of appetite suppressants for treatment of obesity and for weight loss.

Signed: ______________________________ ______________________________
(Patient) (Physician)

Patient Name: ____________________________ Date: ____________Time:__________
(Please Print)

Witness: ____________________________________

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New Patient Consent for Use and Disclosure of Health Information
For treatment, payment, or Healthcare Operations.

I ________________________________, understand that as part of my health care, Lifestyle Solutions Med Spa originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health care professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Lifestyle solutions is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this organization may refuse to treat me as permitted by section 164.506 of the code of Federal Regulations.