Mid-Florida Medical & Chiropractic Center

100 Park Place Blvd Suite 201 Kissimmee, FL 34741
Phone: 407-847-8900 * Fax: 407-931-3500

REGISTRATION FORM

TODAYS DATE: _____/_____/_____

PATIENTS NAME: _____ MR. ☐ MRS. ☐ MISS. ☐ MS. ☐

IS THIS YOUR LEGAL NAME: ☐ YES ☐ NO **IF NOT WHAT IS YOUR LEGAL NAME:** _____

Height_____ **Weight**_____ **Right Handed** ☐ **Left Handed** ☐

MARITAL STATUS: (Please check one) SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOW ☐

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SEX:** MALE ☐ FEMALE ☐ SS# _____

STREET ADDRESS: _____ **CITY:** _____ **STATE/ZIP:** _____

CELL PHONE: (_____**)** _____ **HOME PHONE: (**_____**)** _____

WORK PHONE: (_____**)** _____**E-Mail:** _____

IN CASE OF EMERGENCY: NAME OF LOCAL FRIEND OR RELATIVE

NAME: _____ **RELATIONSHIP:** _____ **PHONE # (**_____**)** _____

Are you: employed ☐ unemployed ☐ retired ☐ disabled ☐ student ☐

(If you are employed please complete the following:)

Where are you employed: _____What type of work do you do?_____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance not paid by my insurance company. I authorize Mid-Florida Medical & Chiropractic Center, Inc to release my medical records and appointment information to my insurance company and/or my attorney to help process my case and/or claim. I also authorize the release of my medical records from Mid-Florida Medical & Chiropractic Center to other physicians who treat me for my condition whilst under the care of Mid-Florida Medical & Chiropractic Center.

Patient's Signature: _____ Date: _____/_____/_____

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HEALTH HISTORY

Please answer all questions completely and accurately

Patient Name: _____

Primary Care Physician: _____ **Office Phone Number:** _____

Estimated Current Weight: _____ **Goal Weight:** _____ **Height:** _____ **Drug Allergies:** _____

List any food Allergies: _____

List any foods that you dislike: _____

_____

List any previous hospitalizations/surgeries/major illnesses:

_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____

Do you drink alcohol: Yes ☐ No ☐ **If yes, how often:** _____
Do you smoke: Yes ☐ No ☐ **If yes, how often:** _____
Do you exercise: Yes ☐ No ☐ **If yes, how often:** _____

Please list any medications that you are currently taking:

Name of medication	Dose & Frequency	Why do you take this medication

FAMILY HISTORY:

Has any blood relative ever had the following:

Heart disease ☐ Epilepsy or convulsions ☐ Alcohol Abuse ☐ Stroke ☐ High cholesterol ☐ Mental retardation ☐
Drug Abuse ☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Mental Illness ☐ Immune Problems ☐
Glaucoma ☐ Liver/Kidney Disease ☐ Additional Family History: _____

YOUR MEDICAL HISTORY:

Have you ever had the following:

Heart disease ☐ High Blood Pressure ☐ High cholesterol ☐ Arthritis ☐ Thyroid disease ☐ Depression ☐ GERD ☐
Sleep apnea ☐ Rheumatic Fever ☐ Tuberculosis ☐ Anemia ☐ Hepatitis ☐ Glaucoma ☐ Stroke ☐
Asthma ☐ Kidney Disease ☐ Diabetes ☐ Bleeding Disorder ☐ Mitral Valve Prolapsed ☐
Cancer, Type _____ ☐

REVIEW OF SYSTEMS:

Do you now or have you had within the past year any of the following:

Weight Change ☐ Swollen Feet/Ankles ☐ Seizures ☐ Skin Rash ☐ Joint / Muscle Pain ☐ Chronic Cough ☐
Chest Pain ☐ Chronic Diarrhea ☐ Fatigue ☐ Headaches ☐ Swollen Lymph Nodes ☐ Jaundice ☐
Anorexia/Bulimia ☐ Blurred Vision ☐ Rapid Heart Beat ☐ Other: _____

I verify that the above information is true and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____

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APPETITE SUPPRESSANTS INFORMED CONSENT

If indicated for your weight loss regimen, Dr. Tai or one of his colleagues at the facility will prescribe Phentermine 37.5 mg as a short-term supplement to diet and exercise. This appetite suppressants is a controlled substances which is regulated by the FDA and has been on the market for several years. Phentermine is a controlled substance and the prescription written and/or dispensed is under the jurisdiction of the DEA. **Sharing this medication with others is strictly prohibited and will result in immediate termination from our weight loss program due to the possible adverse health implications.**

Phentermine is a stimulant that is similar to an amphetamine. Phentermine is an appetite suppressant that affects the central nervous system. Phentermine is used together with diet, exercise and behavioral modification to treat obesity in people with risk factors such as high blood pressure, high cholesterol or diabetes.

Contraindications to this medication are:
* Malignant Hypertension
* Heart Disease
* Hardening Arteries
* Closed Angle Glaucoma
* Regularly taking monoamine oxidase inhibitors (MAOI)
* History of alcohol and / or drug abuse

Phentermine may cause dizziness, blurred vision or restlessness and may hide the symptoms of extreme tiredness. It is imperative that you use caution when driving, operating machinery or performing other hazardous activities until you know how you will react to the medication. Phentermine is habit forming.

I have read and understand the risks of Phentermine. I will follow the guidelines of the weight loss program and utilize the medication only as prescribed.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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ACKNOWLEDGEMENT AND CONSENT FOR WEIGHT LOSS PROGRAM

I authorize Mid Florida Medical & Chiropractic Center to help me in my weight loss reduction efforts. I understand that my program may consist of a balanced calorie restricted meal plan, a regular exercise program, instruction in behavior modification techniques, supplement booster injections and may involve the use of appetite suppressants.

I understand that if appetite suppressants are utilized, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there is certain health risks associated with remaining over weight. *Risk of this program and the use of appetite suppressants may include but are not limited to nervousness, restlessness, dry mouth, fatigue, elevated blood pressure, heart abnormalities, headaches and gastrointestinal irregularities.* These and other possible risks could have long term effects and may be fatal.

I understand that risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart disease, arthritis of the joints, sleep apnea, depression and possible sudden death. These risks may be modest if I am not significantly overweight but will increase with additional weight gain.

I understand that 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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I understand that all supplements will be dispensed from the facility located at Mid-Florida Medical & Chiropractic Center in order to ensure quality and efficacy. I understand that prescriptions for appetite suppressants will not be written for any other purpose by the medical doctor at the facility and will be filled at a local pharmacy of your choice.

I understand that by consenting to treatment that I am financially responsible for payment of my office visits and additional products at the time of service unless some other payment arrangement is agreed upon with the management of Mid-Florida Medical & Chiropractic Center. I understand that refunds are never given under any circumstances. By signing this form I acknowledge that I understand the risks of the proposed treatment and medical staff of Mid-Florida Medical & Chiropractic Center has answered all of my concerns regarding my care.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____