IREVIVE HEALTH & WELLNESS, LLC

PATIENT REGISTRATION AND INFORMATION CONSENT FORM

Name:		**Date:**
Address:		**Sex :** MALE / FEMALE (circle one)
City / State:	**ZIP:**	**Date of Birth:**
E-MAIL:		**Age:**
Primary Phone:		**Height:**
Best Phone Number to Reach You For Follow/Up Call?		
Employer Name / Address:		
How Did You Hear About Our Clinic?		
Name / Phone of Emergency Contact:		
Name / Phone of Primary Doctor:		

MEDICAL HISTORY

Have you had the following diseases or conditions? (Please check all that apply with year of diagnoses)

	No	*Yes*	*Date*		*No*	*Yes*	*Date*
Heart Disease (Heart attacks, failure, murmurs)				Kidney or Bladder Disease			
High Blood Pressure				Blood Clot Disorder			
Thyroid Disease				Cancer			
Strokes or Paralysis				High Blood Cholesterol			
Anxiety / Depression				Stomach Disorder			
Epilepsy / Seizures				Gall Bladder Disease			
Liver Disease (cirrhosis, hepatitis, yellow jaundice)				Lung Disease (asthma, emphysema, tuberculosis)			
Anemia or other blood disorder				Skin Disorder (unusual			
Diabetes				or recently changed moles)			
Glaucoma or other eye disorder				Rheumatic Fever			
Anorexia / Bulimia				Arthritis			

FAMILY HISTORY (**diabetes, high blood pressure, heart disease, etc…**)

Family Member	Diagnoses

HOSPITALIZATIONS / SURGERIES

Year	Reason

LIST ANY ALLERGIES TO MEDICATION OR FOOD

Allergy	Reaction

DAILY MEDICATIONS

Include all over-the-counter and prescription medication such as: antacids, aspirin, anti-depressant or anti-psychotic medication, birth control pills, cortisone, laxatives, vitamins, tranquilizers, sleeping pills, sedatives, appetite suppressants, blood pressure medicine, seizure medication, thyroid medication. Have you ever taken: insulin, tablets for diabetes, hormone replacement.

Name of medication	Daily Dosage

SOCIAL HISTORY

Marital Status: □ Married □ Single □ Widowed □ Divorced □ Separated

Number of Children: _____

Are you currently pregnant? □ Yes □ No _____(initial here)

Date of last Menstrual cycle? _____

Tobacco use? _____ Type?_____ How often?_____

Have you ever been treated for depression or for any mental disease or disorder? □ Yes □ No

Describe: _____

Have you ever been treated for alcoholism? □ Yes □ No Drug abuse? □ Yes □ No

PATIENT REGISTRATION AND INFORMATION CONSENT FORM

1.) I, _____ (patient or patient's guardian) authorize IRevive Health & Wellness, LLC to assist me in my weight reduction efforts.
2.) IRevive Health and Wellness' licensed professionals' experience and clinical studies have found that Phentermine may be helpful for long term use, along with a comprehensive weight loss program, even though the F.D.A. recommends its use based on short-term studies. IRevive's professional staff believes that the probability of side effects from the longer use of Phentermine is outweighed by the benefit of the appetite suppressant.
3.) I understand it is my responsibility to follow the instructions carefully and to report any significant medical problems that may be related to my weight control program as soon as possible.
4.) I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.
5.) I understand this authorization is given with the knowledge that the use of the appetite suppressants involves some side effects. The more common include dry mouth, constipation, or nervousness, elevated blood pressure and heart rate.
6.) 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.
7.) I understand that not all medications have been evaluated by the food and drug administration. Some medications used are in the conceptual phase and have not passed the extensive FDA testing and regulation approval process.
8.) I understand that IRevive Health and Wellness, practitioners and medical staff, take precautions to decrease any risk of health related complications associated with intramuscular injections, but there is still a potential low risk of complications including but not limited to: bruising, pain, infection at IM site, and Anaphylaxis reaction to medications.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE WEIGHT LOSS PROGRAM, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENTS, ASK A MEMBER OF THE MEDICAL STAFF BEFORE SIGNING THIS CONSENT FORM.

PATIENT SIGNATURE: _____ DATE: _____
(Or person with authority to consent for patient)

PHYSICIAN SIGNATURE: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers for my health care services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____