



Urgent Care • Weight Management • DOT Physicals

Patient Information Form

Patient Name _____ Today's Date _____

Age _____ Date of Birth _____ Sex: M F Patient Height _____

Cell Number _____ Ok to text? Y N Social Security#: _____

Address _____

City _____ State _____ Zip: _____

Occupation _____ Employer _____

Employer Phone Number _____

Emergency Contact Name: _____ Relationship _____

Emergency Contact Phone Number _____

For Weight Management Patients: By signing this document, I am certifying that I have been unsuccessful at all reasonable attempts to lose weight using diet/exercise for at least 90 days prior to my appointment. I understand the risks/benefits of prescription weight loss medications and agree to discuss any concerns with my provider. I also consent to prescription doses that may be higher than FDA recommended doses for periods longer than FDA recommended as directed by my provider and consent to off-label uses of any medications as directed by my provider.

Patient/Guardian Signature _____



Date _____

Name _____

Allergies to Drugs/Foods:

Current Medications:

Past Surgical History:

Past Medical History:

Family's Medical History (Parents and Siblings only)

Smoke? Yes No

Chew Tobacco? Yes No

Drink Alcohol? Yes No

If yes, how much/often? _____

Drug Use? Yes No

If yes, what and how often? _____

Have you ever taken over-the-counter or prescription appetite suppressants before? Yes No

If yes, what? _____ For how long? _____

How long since your last dose? _____

How did you hear about us? Facebook Joplin News First TV Other

Referral: **Who referred you?** _____

GARDNER EXPRESS CARE

TELEMEDICINE, WEBSITE, SOCIAL MEDIA, AND CELLULAR (SMS) TEXT/CALL INFORMED CONSENT

I expressly and universally give Gardner Express Care (GEC) consent to use the above technology to exchange protected and private healthcare information using the “Facebook” and/or “Messenger” or any other web-based texting apps and/or websites. I understand that the messages to our staff will only be viewed for medical purposes only and not be shared unless express written consent is obtained from the patient.

I also give consent to share on GEC's website and/or Facebook page any before and after photos of treatment received at GEC and further verify this consent by sending before and after photos to GEC via any of the above technology.

Print Patient Name

Date

Signature