Weight Loss Program Registration Form

DEMOGRAPHICS: **Date:**_____

Full Name:

Social Security #: Date of Birth:

Gender: _____ M _____ F Marital Status: _____

Address: Apt#.:

City: State: Zip Code:

Home Phone: Cell Phone:

Emergency Contact Name: Phone #:

E- mail:

How did you hear about us?

HISTORY:

Any History/Current Medical Illness? _____ Y es _____ No
If Yes, please check if applicable:

☐ Heart Disease ☐ Hypertension/High BP ☐ Blood Disease

☐ Stroke/Aneurysm ☐ Diabetes ☐ Cancer

Other:

List Current Medications

Are you allergic to any medications? _____ Yes _____ No

If yes, please list them below:If yes, please list them below:

What is your ideal weight? _____ lbs.

What weight loss program have you decided to register in? (please check program desired)

MEDICATION PROGRAM * ☐ *CASH ☐ HCG 26 Day Program

☐ *WITH INSURANCE ☐ HCG 43 Day Program

INSURANCE NAME:

ID #: