

PATIENT INFORMATION SHEET

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX (CIRCLE): M OR F

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**ADDITIONAL INFORMATION:**

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY:

\_\_\_\_\_

PHONE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

**I UNDERSTAND THAT PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT hCG WEIGHT LOSS CLINIC, LLC DOES NOT BILL INSURANCE COMPANIES AND THEREFORE, I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES**

\_\_\_\_\_  
Client Signature