PATIENT INFORMATION FORM

Personal Information:

Patient Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Birth date: _____ Age: _____ Sex: [M] [F] SSN#: _____-_____-_____

E-mail address: _____

How did you hear about us? _____

Employment Information:

Occupation: _____ Employed by: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____

Family Physician: _____ Phone: _____

Financial Policy:

Thank you for selecting Diet Solution Centers for your weight loss needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and Discover.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Printed Patient Name: _____

Patient Signature: ____ Date: ____________________________________