



Robert L. Bartemus, DO

Janice P. Gregory, ARNP

o 1670 E. Highway 50, Suite E, Clermont, FL 34711
352-243-5673

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407-897-5673

www.doctorsweightcontrol.com

Patient Information Form:

Name:(last) _____ (first) _____ (m.i.) _____ SSN: _____

Patient Address: _____

City _____ State _____ Zip Code _____

Home Phone: () _____ Cell Phone : () _____

Birth Date: _____ Age: _____ Sex: (M / F)

Alternative address _____

Email Address: _____

Do we have your permission to email you information on specials and newsletters? Yes or No _____

Drivers License # _____ State: _____

Education: Elementary High School/Tech School 2 Year College 4 Year College Graduate School
(Please circle highest level achieved)

Employment Information:

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Phone:() _____ ext: _____

In Case of Emergency:

Name: _____ Relationship _____ Phone:() _____

Patient's Spouse: _____ Phone:() _____

Referred by: _____

How did you hear about us?

___ Lake County Yellow Pages ___ Orange County Yellow Pages ___ Mailer/Advertising

___ Referral by Current Patient ___ Newspaper Ad ___ Sign/Location

___ Coupon Book ___ Referral by Employee of DWC ___ Radio Advertising

My Signature on this form confers the authorization for Medical treatment by Robert L. Bartemus, DO and his Staff at Doctor's Weight Control.

Financial Policy:

Thank you for selecting Robert L. Bartemus, DO for your weight control 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. For you convenience we accept Visa, Master Card, Discover Card, Personal Checks with proper identification and Cash.

Patient's Signature

Date

Acknowledgement

I certify that I have received the Doctor's Weight Control Insurance Portability and Accountability Act (HIPPA) information as is required by law to begin by 4/14/03. I understand that it is my responsibility to read through the given information, make any requests, and provide documentation that may protect my confidentiality within this practice.

Please read the list below and make any requests at this time. If no request or correction is made, the procedure will remain as written.

- 1 Doctor's Weight Control reserves the right to call the given home/work phone number to confirm scheduled appointments the day prior to scheduled appointment: _____

- 2 If upon calling, we receive a voice mail message, we will say that we are calling to confirm an appointment with Dr. Bartemus with the scheduled time.

Name (Print): _____

Signature: _____

Date: _____

Staff Signature: _____

Date: _____



Cautionary Statement Concerning Use of Prescription Appetite Suppressants

Some patients may not be good candidates for prescription appetite suppressant use due to various reasons:

- 1. Due to potential side effects from these medications or previous known side effects from taking these medications.**
- 2. Potential adverse interactions with other prescription medications or over the counter medications that a patient might already be taking. Please notify our staff and doctor of any current medications you are taking or may have recently taken.**
- 3. Absolute contraindications due to medical history in some patients such as those with a history of:**
 - a. Cardiovascular Disease, Previous Heart Attacks, Stroke, Documented Angina, Abnormal Heart Rhythm, Untreated Hypertension (elevated blood pressure)**
 - b. Diabetes Mellitus, Uncontrolled or poorly controlled with medications. Diabetic patients on weight control programs need to monitor their blood sugars closely, and adjust medication dosage as dictated by their primary care physician.**
 - c. Neurological Abnormalities such as undiagnosed weakness, history of chronic undiagnosed headaches or multiple sclerosis.**
 - d. Anxiety/Panic Disorder, controlled or uncontrolled with medication use.**
 - e. Current therapy with certain antidepressant medications (SSRI class medications)**
 - f. Glaucoma in one or both eyes.**
 - g. Thyroid disorders, except those with adequately treated and monitored under-active thyroid disease.**
 - h. Patients who are pregnant or are trying to conceive, should not be taking prescription appetite medications. Please notify our staff or doctor should you have any missed or irregular periods.**
 - i. Mothers who are breastfeeding should not use prescription appetite suppressants.**
 - j. Patients with a history of alcohol and/or drug abuse should not use appetite suppressants.**
- 4. Age may also be a factor in prescribing these medications and is at the discretion of the examining and treating physician.**
- 5. Certain physical findings such as heart murmurs or carotids bruits or unexplained leg edema may prohibit the use of these medications.**

Patient Acknowledgment of Cautionary Statement

I agree to complete a comprehensive history form that will be reviewed by our staff and the treating physician, Robert L. Bartemus, DO. I agree to disclose any past or current medical conditions or problems that may exist or would be consistent with any of the above. I have read and I understand that the above conditions and contraindications that are outlined in the previous page. I further understand that I will be given ample opportunity to ask the treating physician, Robert L. Bartemus, DO about any possible prescription medications that may be used in my care for weight management along with any potential side effects of such medications. I also agree to notify this office of any potential adverse side effects that may occur following the use of any appetite prescription medications that may be prescribed. I agree that I will not consume alcohol or other contraindicated drugs while using any appetite suppressants as prescribed by this office. I further understand that upon withdrawal from this program, I will not be entitled to a refund of any previously paid monies.

Patient's Signature

Patient's Name Printed

Robert L. Bartemus, DO

Date



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Weight Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight loss program. Consult your physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support and educational components; receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to Section 468-505(1)(j), Florida Statutes.

Required to be posted by Section 501.0575 of Florida Statutes

I have read the above statement:

Patient Signature

Date