



Desert Wellness Center

Family Medicine using Modern Science and Ancient Wisdom

Patient Information Form

Name: _____ DOB: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email: _____

In the Event of an Emergency, Please Contact: _____

Relationship to the Patient: _____ Phone Number: _____

Insurance Company: _____

Group Number: _____ Policy Number: _____

Claims Address: _____

Insured: _____ Relation to Patient: _____

I acknowledge that I have received a copy of Desert Wellness Center's Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship to patient



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Consent for Human Chorionic Gonadotropin (HCG) Weight-Loss Program

I, _____, request and consent to Injections of HCG and strict dietary restrictions for the purpose of losing weight. I understand that as part of the program I will be given a limited physical and orientation to the program, will be instructed on how to administer the injections myself or make arrangements to have someone do so. I understand that initial blood tests will be performed to rule out any conditions that would disqualify me from the program or require any prior treatment before starting the program. I agree to immediately report any problems that might occur to the medical provider during the treatment program. I further understand that there could be risks involved as there are with all medications and that not complying with the dosage recommendations and dietary restrictions could increase risks and alter the results.

I understand that HCG is **not** FDA approved for weight loss. I also understand that there is no medical evidence to support use of HCG for this purpose. The FDA requires the following statement; "HCG has not been demonstrated to be effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets."

Patient responsibility: If you miss a scheduled appointment, it will be your responsibility to call our office to reschedule.

REFUND POLICY: Once labs are done, the physical is performed, and the treatment is started, we cannot honor any refund requests based on scheduling conflicts, missed doses, unsatisfactory results, other conflicting medical opinions, other health problems that might concurrently arise, or any other reasons.

I have read and understand all of the above. I fully understand what I am signing and hereby request and consent to Anti- Aging/weight-loss treatment using injections of HCG.

Patient Signature _____ Date: _____



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (PLEASE PRINT):

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

RELEASE MY MEDICAL RECORDS FROM:

Doctor's Name: _____

Address: _____

Phone #: _____

Fax #: _____

RELEASE MY MEDICAL RECORDS TO:

Dr. Courtney Cronin, NMD
Desert Wellness Center
44480 W. Honeycutt Rd, #107
Maricopa, Az 85238

Phone: (520) 431-1080
Fax: (520) 423-3001

Please release a copy of all my medical records, including but not limited to, progress notes, operative reports, laboratory results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient or Representative: _____ Date: _____

Relationship to the Patient: _____



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New Patient Intake

Name: _____ Date of Birth: _____ Today's Date: _____

List of Complaints (in order of importance):

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies to Medications/Food:

1. _____
2. _____
3. _____
4. _____
5. _____

Weight History

When did you first become overweight? (your age then) _____ (year) _____

How did your weight gain start? Describe any circumstances: _____

What do you think is the cause of your weight problem? _____

Your present weight: _____ your weight goal: _____ height: _____

What was your highest weight? (excluding pregnancy) _____ your age then _____ # of years ago _____

What was your lowest weight? _____ your age then _____ # of years ago _____

Have you ever stayed the same weight for 10 years or more? Yes/ No

Have you attempted to lose weight before? _____ most lbs lost: _____ how long it took: _____

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results: _____

Where and when do you do most of your overeating? _____

Please make any comments that you think might be helpful: _____

Exercise: How often: _____ Type: _____

Sleep: Amount: _____ Wake Refreshed? _____ Trouble Falling or Staying Asleep? _____

Please describe your typical meals:

| Breakfast | Lunch | Dinner |
|-----------|-------|--------|
| | | |

Snacks: _____ Beverages: _____



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Current Medications and Supplements (include dosage): _____

Previous Surgeries and Hospitalizations, include date: _____

Please list date of your last:

Blood Work: _____ Dental Exam: _____ Eye Exam: _____

Colonoscopy: _____ Chest x-ray: _____ Other Imaging: _____

Pap Smear: _____ Bone Scan: _____ Mammogram: _____

Please indicate if you have had the disease (D) or were immunized (I):

Measles: D I Mumps: D I Rubella: D I Hemophilis (Hib): D I

Tetanus: D I Shingles: D I Chicken Pox: D I Hepatitis B: D I

HPV: D I Whooping Cough: D I German Measles: D I Other: _____

Family History

| <u>Family Member</u> | <u>Age if Living</u> | <u>Age of Death</u> | <u>Reason of Death</u> |
|----------------------|----------------------|---------------------|------------------------|
| Mother | | | |
| Father | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Siblings | | | |
| Children | | | |

| <u>Disease</u> | <u>Family Member</u> |
|--------------------------|----------------------|
| Heart attack/stroke | |
| Cancer (include type) | |
| Mental Illness | |
| Heart Disease | |
| High Blood Pressure | |
| Diabetes | |
| Asthma/allergies | |
| Autoimmune(RA,Lupus,etc) | |



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Please indicate Yes (Y), No (N), or Past (P):

Antacids: Y N P Smoking: Y N P Packs per day & number of years _____

Analgesics: Y N P Coffee: Y N P Cups per day if yes or past _____

Laxatives Y N P Alcohol Y N P Amount if yes or past _____

Steroids Y N P Soda Y N P Amount if yes or past _____

Recreational Drugs Y N P

Addictions and/or treatment for addictions: Y N P Explain: _____

Social Life:

Job: _____ Enjoy Job? _____

Hobbies: _____

Relationship: Married Single In a relationship

Satisfied with Significant Relationship? _____

History of Mental/Physical/emotional Abuse? _____

Review of Systems

Circle Yes (Y), No (N) or Past (P):

Skin:

| | | |
|------------------|---------------|----------------------|
| Rash: Y N P | Eczema: Y N P | Color Change: Y N P |
| Hives: Y N P | Cancer: Y N P | Abnormal Mole: Y N P |
| Psoriasis: Y N P | Warts: Y N P | Dry/ Itchy: Y N P |

Head:

| | | |
|------------------|------------------|----------------------|
| Migraines: Y N P | Dandruff: Y N P | Oily/dry Hair: Y N P |
| Headache: Y N P | Hair Loss: Y N P | Head Injury: Y N P |

Nose:

| | | |
|--------------------|-------------------|-------------------------|
| Nose bleeds: Y N P | Allergies: Y N P | Frequent Colds Y N P |
| Polyps: Y N P | Congestion: Y N P | Problems Smelling Y N P |

Eyes:

| | | |
|----------------|------------------|-------------------------|
| Dryness: Y N P | Cataracts: Y N P | Pain: Y N P |
| Itching: Y N P | Glaucoma: Y N P | Watery/Discharge: Y N P |
| Redness: Y N P | Styes: Y N P | Vision Problems: Y N P |

Mouth/Throat/Neck:

| | | |
|-----------------------|-----------------------|----------------------------|
| Cavities: Y N P | Goiter: Y N P | Problems speaking: Y N P |
| Dentures: Y N P | Gum Disease: Y N P | Problems tasting: Y N P |
| Sores: Y N P | Sore throat: Y N P | Problems swallowing: Y N P |
| Neck Stiffness: Y N P | Swollen Glands: Y N P | |

Respiratory:

| | | |
|------------------|-------------------|----------------------------|
| Asthma: Y N P | Cough: Y N P | Shortness of Breath: Y N P |
| Emphysema: Y N P | TB: Y N P | Wheezing: Y N P |
| Pneumonia: Y N P | Bronchitis: Y N P | Pain with Breathing: Y N P |



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Cardiovascular:

| | | |
|---------------------|------------------------|----------------------------|
| Palpitations: Y N P | Heart Attack: Y N P | High Blood Pressure: Y N P |
| Chest Pain: Y N P | Rheumatic Fever: Y N P | Arrhythmias: Y N P |
| Murmurs: Y N P | Edema: Y N P | Blood Clots: Y N P |

Urinary Tract:

| | | |
|---------------------|-----------------------|----------------------------|
| Incontinence: Y N P | Kidney Stones: Y N P | Frequent Infections: Y N P |
| Urgency: Y N P | Blood in Urine: Y N P | Pain with Urination: Y N P |

Gastrointestinal:

| | | |
|---------------------|----------------------|-----------------------------|
| Heartburn: Y N P | Vomiting: Y N P | Change in Appetite: Y N P |
| Indigestion: Y N P | Ulcers: Y N P | Gall Bladder Disease: Y N P |
| Gas/Bloating: Y N P | Hemorrhoids: Y N P | Pancreatitis: Y N P |
| Constipation: Y N P | Liver Disease: Y N P | Stomach Pain: Y N P |
| Diarrhea: Y N P | Nausea: Y N P | |

Male Genitalia:

| | | |
|------------------|-------------------------|---------------------------------|
| STD's Y N P | Hernia: Y N P | Erectile Dysfunction: Y N P |
| Discharge: Y N P | Prostate disease: Y N P | Testicular Pain/swelling: Y N P |
| Pain: Y N P | Sexually Active: Y N P | Frequent Night urination: Y N P |

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Female Genitalia:

Age of First Menses: _____ First Day of Last Menses: _____ Length of Menses: _____

Age of Menopause: _____ Birth control previously or currently used: _____

Times Pregnant: _____ Children: _____ Miscarriages: _____ Abortions: _____

Sexual Orientation: Heterosexual Homosexual Bisexual Other

| | | |
|----------------------|------------------------|------------------------------|
| Abnormal Paps: Y N P | Discharge: Y N P | Pain with intercourse: Y N P |
| PMS: Y N P | Odor: Y N P | Healthy Libido: Y N P |
| STD: Y N P | Heavy Bleeding: Y N P | Sexually Active: Y N P |
| Vaginitis: Y N P | Vaginal Dryness: Y N P | Menstrual Cramping: Y N P |

Musculoskeletal:

| | | |
|------------------|------------------|-------------------|
| Weakness: Y N P | Tremors: Y N P | Leg Cramps: Y N P |
| Stiffness: Y N P | Arthritis: Y N P | Pain: Y N P |

Nervous:

| | | |
|------------------|-----------------|--------------------------|
| Paralysis: Y N P | Sciatica: Y N P | Numbness/Tingling: Y N P |
| Seizures: Y N P | Fainting: Y N P | Carpel Tunnel: Y N P |

Mental/Emotional:

| | | |
|------------------------|---------------------|------------------------------|
| Depression: Y N P | Suicidal: Y N P | Psych Hospitalization: Y N P |
| Anxiety: Y N P | Fear/Panic: Y N P | Bipolar: Y N P |
| Eating Disorder: Y N P | Irritability: Y N P | Obsessive: Y N P |



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NOTICE OF PRIVACY PRACTICES

To Our Patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated but we must provide you with the following important information:

Use and Disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help you prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Worker Compensation and similar programs.

Your rights regarding your health information:

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Desert Wellness



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Center, 44480 W. Honeycutt Rd., #107 Maricopa, Az 85138. *We must respond to this request within 30 days.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be submitted in writing to Desert Wellness Center, 44480 W. Honeycutt Rd., #107 Maricopa, Az 85138. You must provide us with a reason that supports your request for amendment. *We must respond within 60 days. The patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at Desert Wellness Center. All complaints must be submitted in writing. You will not be penalized for submitting a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law.

If you have any questions regarding this Notice or our health information privacy policies, please contact the Office Manager at Desert Wellness Center.