

Doctor's Weight Solutions

4701 Creedmoor Road, Suite 101, Raleigh, NC 27612
www.doctorsweightsolutions.com 919-782-9992

Patient Information Form

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

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Beeper/Cellular: (____) _____

E-mail address: _____

Birth Date: ____/____/____ Age: _____ Sex: M F

Country of Birth: _____ Country of Parents' Birth: _____ (optional)

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____ Ext. _____

Social Security: _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: (____) _____

Patient's Spouse _____ Phone: (____) _____

Family Physician _____ Phone: (____) _____

Referred by: _____

How Did You Hear About Us? (Check all that apply)

Bell South Yellow Pages Sign/Location Search Engine (Which?) _____

Referral by Current Patient Yahoo Yellow Pages Other _____

Doctor's Office (Which?) _____

Financial Policy:

Thank you for selecting Dr. Sheila Patterson 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, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, American Express, personal checks and cash.

Patient's Signature

Date