The Youth Fountain, LLC

501 Iron Bridge Road, Suite 9
Freehold, NJ 07728
(866) 514-0025

Weight Loss Form

Name: _____ Date: _____

Birthdate: _____ Last 4 digits of your Social Security Number: _____ Female: _____ Male: _____

Primary Care Physician: _____ Phone Number: _____

How did you hear about us? _____

Current Medications/Supplements and Doses: _____

_____

Allergies/Reactions: _____

Past Medical History: _____

_____

Past Surgical History: _____

Family History: _____

Smoke, if yes how much? _____ Drink alcohol, if yes how much? _____

Recreation drugs, If yes how much? _____ Plan on becoming pregnant soon? Yes / No

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Have you heard of:	Yes	No	Do you have:	Yes	No
CoolSculpting			Muffin-Top		
Plasma Facelift			Love Handles		
TruSculpt			Extra arm fat		
IV Therapy			Sagging Skin / Lumpy Knees		
Microneedling			Cellulite		
Pico Genesis			Saddlebags		
VI Peel			Acne Scars		
EmSculpt			Double Chin		

What feature do you wish you could change? _____

Goals for weight loss? _____

Health Habits & Personal Safety

Exercise	
Sedentary (no exercise)	
Mild Exercise (i.e. climbing stairs, walking three blocks, golf)	
Occasional vigorous exercise (i.e. work or recreation less than 4 times per week for 30 minutes)	
Regular vigorous exercise (i.e. work or recreation 4 times per week or more for 30 minutes or more)	

Weight History	
What was your weight at age 18?	
Lowest adult weight in past 5 years?	
Highest adult weight?	
What is the main reason you decided to lose weight?	
When did you begin gaining weight?	
What do you think is the main cause of your weight problems?	
What do you feel will be your obstacle(s) to successful weight loss?	

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Diet History	
Are you currently dieting?	What was the biggest loss in pounds you had on a diet?
Have you been on a physician-prescribed diet?	Did you regain this weight?
How many meals do you eat on an average day?	How long did it take you to lose this weight?
What food do you avoid?	How long did it take you to regain this weight?
What foods do you crave?	Do you ever feel full when eating?
Do you awaken hungry during the night?	Do you have a food addictions?
What is your typical breakfast?	
What is your typical lunch?	
What is your typical dinner?	
What are your worst food habits?	
What are your worst snack habits?	

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information. Please read it carefully before signing.

The Youth Fountain, LLC will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THE AFOREMENTIONED AUTHORIZATION.

By signing this authorization, you acknowledge and agree that The Youth Fountain, LLC may not use or disclose any health care related documentation for the purpose(s) of treatment or management of the patient's health without patient permission.

By signing this authorization, you agree that The Youth Fountain, LLC or its Business Associates may not disclose your personal health care information to a requesting entity or health care provider without your express permission.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand The Youth Fountain, LLC Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While The Youth Fountain, LLC has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from The Youth Fountain, LLC at any of its offices.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by The Youth Fountain, LLC for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that The Youth Fountain, LLC has taken action in reliance on it. A revocation is effective upon receipt by The Youth Fountain, LLC of a written request to revoke and a copy of the executed authorization form be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of The Youth Fountain, LLC or (d) six years from the date this authorization was executed.

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

The Youth Fountain, LLC will provide the undersigned with a copy of this signed authorization at his or her request.

Acknowledge and agreed to by:

Patient Name: _____ Date: _____

Patient Signature: _____

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Patient Registration Form

Patient Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birthdate: _____ Female / Male

SSN (Last 4 Digits): _____ Email Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

How would you prefer to receive automatic appointment reminders? ☐ Text ☐ Call ☐ E-Mail

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone Number: _____