OCONEE WEIGHT & WELLNESS
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Email Address:		Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:		Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize OCONEE WEIGHT & WELLNESS or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

HIPAA Privacy Notice

At Oconee Weight & Wellness (OWW) we are honored you chose to partner with us on your journey to your best health. Our clinic utilizes the very latest information technology to record and analyze your personal health information. The guidelines which govern the privacy, use and your rights in regards to your personal health information (PHI) have been codified into a series of laws known as HIPAA. OWW has posted a link to the HIPAA regulations on our website www.OconeeWW.com. All of our employees and Providers have been trained on the proper use and handling of your Personal Health Information (PHI). Our utmost aim is to protect your privacy while at the same time only sharing information on a need to know basis with other Health professionals involved in providing you care or payment of your claims. By signing below you acknowledge that OWW has made you aware of how to access your PHI, HIPAA policies and your responsibilities.

Signature of Patient, Parent, Guardian or Personal Representative — Date

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Staff Reviewed — Date

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Medications		
Name	Strength	Frequency Taken

Do you have any drug allergies? If so, please list them:

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.							
Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you dieting?			☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?			☐	Yes	☐	No
	# of meals you eat in an average day?						
	Rank salt intake	☐ Hi	☐ Med	☐ Low			
	Rank fat intake	☐ Hi	☐ Med	☐ Low			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Alcohol	Do you drink alcohol?			☐	Yes	☐	No
	If yes, what kind?						
	How many drinks per week?						
Tobacco	☐ Cigarettes - #/day ☐ Pipe - #/day ☐ Cigars - #/day ☐ # of years ☐ Or year quit						

Please list your goals for partnering with OWW:

No Show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient.

A “no show” is missing a scheduled appointment. A “late cancellation” is canceling an appointment without calling us to cancel 24 hours in advance of an office visit.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

If you “no show” or have a “late cancellation” we will require a $50.00, non-refundable, deposit to be applied to your next visit fee, when rescheduling.

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____________________ ______________________________
Date Signature