BE-LITE MEDICAL CENTER INITIAL INTAKE FORM

A. Demographic information.

Item Requested **Answer**
Last Name, First Name, Middle Initial
Street City State Zip Code
Name, phone number (or city), of your primary care physician
State
Zip Code
Date of Birth (MM/DD/YYYY)
Home Phone (with area code): Email: Work Phone (with area code): Cell Phone::
Occupation
Referred by: Person_____ Internet Google _____ Yelp_____
If you have ever smoked cigarettes Age of first use Date of last use Total years of use Number of cigarettes/day currently

B. Please rate the intensity of any of the following symptoms you've had in the last week:

0 **0=No Problem**	**1** **1 = Minor Problem**	**2** **2 = Big Problem**
Hunger	Diarrhea	Rapid Heart Rate
Cravings	Constipation	Palpitations
Mood Swings	Hot flashes	Insomnia
Irritability	Dizziness	Anxiety
Headache	Dry mouth	Shortness of breath
Feeling "wired"	Blurred vision	Difficulty Urinating
Skin rash	Excess Urination	Excess Thirst

BE-LITE MEDICAL CENTER MEDICAL HISTORY FORM

C. Additional items.

Item Requested	**Answer**
Age	Height (feet, inches) Highest weight ever
How many weight loss programs have you participated in? Please name them.	
How much alcohol do you drink per week?	What type of alcohol?
Have you ever used prescription diet pills before? (Yes or No)	
Have you ever used over-the-counter diet pills before? (Yes or No)	
What medicines are you **allergic** to?	
What **surgery** have you had?	
Are you pregnant? Do you take birth control pills? When was your last menstrual period? Are you breast feeding?	
Do you have a family history of diabetes, heart attacks or stroke?	
Do you exercise regularly? What kind of exercise do you enjoy? What do you do?	

Please check the list below if you currently have or have ever had any of these conditions.	
Diabetes	Seizures
Thyroid problems	Heart problems/Palpitations
Stroke	High Blood Pressure
Back pain	Joint pain/Arthritis X
Cancer	Hypoglycemia (low blood sugar)
Excess use of drugs or alcohol	Psychiatric Problems
Asthma	Glaucoma
Please list any medications you are taking?	

It is important that you answer all the above questions. A blank answer will be assumed to be a no.

Signature_____ Date_____

BE-LITE FOR LIFE MEDICAL CENTER

NOTICE REGARDING FILLING PRESCRIPTIONS AT THE BE-LITE PHARMACY OF FAIRFAX

The BE-LITE Pharmacy of Fairfax is a licensed specialty compounding pharmacy located on-site. Most of our patients choose to have their prescriptions issued by the medical practitioner filled at this pharmacy, because it saves them the inconvenience of having to make an additional trip to their local pharmacy. We will gladly provide patients with prescriptions that they can have filled at the pharmacy of their choice. The purpose of this note is to 1) document that patients have been notified of their right to have prescriptions filled at their pharmacy of choice and 2) to document that patients have been notified that Dr. Rothman is a co-owner of the BE-LITE Pharmacy of Fairfax.

Patient's Signature Date

MEDICAL INSURANCE POLICY OF THE BE-LITE FOR LIFE MEDICAL CENTER

The BE-LITE FOR LIFE MEDICAL CENTER requires payment at the time services are delivered. Although we do not accept third party payments, we do encourage patients to file for reimbursement with their insurance companies. To facilitate this process we will provide, at your request, a receipt with a diagnosis code and CPT (procedure) code, which most companies require. This procedure works for many patients, but sometimes situations arise which require greater time input on our part. We will be pleased to assist patients in their efforts to obtain reimbursement in these cases, but we do have to charge $5 to $15 to cover the time and expense required to provide this assistance. Patients will be expected to pay this charge even if the Insurance company ultimately declines to pay them. By signing below, the patient gives us permission to process these requests from Insurance companies and charge their accounts $ 5 to $ 15 for this service. Typical examples of such situations include: **1)** The insurance company makes the check payable to the BE-LITE FOR LIFE MEDICAL CENTER or one of our doctors, not the patient, even though the patient already paid. (Charge of $5.00). **2)** The insurance company requests a copy of a chart, clinical notes, or a note from the doctor (Charge of $15.00). **3)** The insurance company requires that their own special form be filled out (Charge of $15.00).

Patient's Signature Date

BE-LITE FOR LIFE MEDICAL CENTER POLICY ON BOUNCED CHECKS AND MISSED AND LATE APPOINTMENTS

Patients will be charged $25 when their check bounces for insufficient funds, if the payment is stopped or because the account is closed. When an appointment is scheduled for a patient, we turn other patients away who could otherwise be scheduled into the appointment slot. Therefore, the BE-LITE FOR LIFE MEDICAL CENTER requires at least 24 hours notice if a patient wishes to cancel an appointment. If a patient does not show for their scheduled appointment without having canceled it, then we will charge their account $25. Coming late for an appointment inconveniences other patients and makes it impossible for us to staff the Center so as to minimize the wait. We therefore charge patients $5 if they are 20 mins late and $10 if they are more than 45 mins late. Patients who walk-in for unscheduled appointments will be charged $10 extra. Exceptions can be made by the Manager for extenuating circumstances.

Patient's Signature Date

NOTICE REGARDING STARTING AN EXERCISE PROGRAM

Keeping physically active is key to a healthy lifestyle. Its always a good idea to check with your doctor before starting a new exercise program, especially if you are unsure of your health status, have multiple health problems or physical/health limitations.

Patient's Signature Date

NOTICE REGARDING THE VIRGINIA PRESCRIPTION MONITORING PROGRAM

The Virginia Prescription Monitoring Program is a a state-maintained database that collects information on all controlled substance prescriptions dispensed by pharmacies in Virginia (https://www.dhp.virginia.gov/dhp_programs/pmp/). The BE-LITE FOR LIFE MEDICAL CENTER participates in this program, and a query to the database is made for all new patients and periodically thereafter. This note provides notification of this policy.

Patient's Signature Date

BE-LITE MEDICAL CENTER INITIAL INTAKE FORM

	WEEKDAYS	WEEKENDS
BREAKFAST		
LUNCH		
DINNER		
SNACKS		
DRINKS		
SUGGESTIONS:		