Sunrise Health Medical Group, Inc.

PATIENT INFORMATION SHEET

Today's Date: _____

Patient Name: _____Birthdate: _____Age: __
Title First MI Last

Address: _____ Soc. Sec. # _____
No. & Street City, State, ZIP

Employer: _____ Occupation: _____

Home Phone: _____ Work Phone: _____

Spouse or S.O.'s Name_____

Emergency Contact (Name and Phone): _____

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How did you learn about our offices? _____
(Friend, doctor, newspaper ad, yellow pages, etc.)

Have you tried other weight control programs? Which? _____

_____

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PLEASE BE AWARE THAT THERE IS A $25 CHARGE FOR RETURNED CHECKS. THANKS FOR USING YOUR CREDIT CARD OR DEBIT CARD (ATM CARD) IF YOU CAN.

A large number of studies have documented a much greater rate of successful weight loss among people who come regularly for weigh-ins and counseling. Please do your best to come regularly at least once a week. We offer a discount from our regular weekly rate for multiple prepaid weeks to encourage you to do so.

Our fees revert to the standard weekly rate if you miss a week while on the discounted rate, and what you have paid will be pro-rated. If you miss coming for six weeks or more, a re-start fee of $25 may be charged.

OPTIONAL: I authorize the release of any medical information necessary to process insurance claims connected with the services provided by this office.

Signed (Insured or Authorized Person) _____Date _____