



Patient History Form (FEMALE)

PATIENT **LEGAL** NAME: _____ AGE: _____ D.O.B. ____/____/____

CURRENT MEDICATIONS: _____

MEDICATION ALLERGIES: _____

BLOOD TYPE: _____ If you don't know, we will type you at your appointment today.

History of Bariatric Surgery? Y / N If yes, please explain: _____

Do you smoke? Y / N If yes, how much and how long? _____

Do you drink alcohol? Y / N If yes, how much and how long? _____

Do you have a history of addiction? Y / N

Have you ever been diagnosed with an eating disorder? Y / N

IS THERE A FAMILY OR PERSONAL HISTORY OF ANY OF THE FOLLOWING?

	<u>FAMILY</u>	<u>PERSONAL</u>		<u>FAMILY</u>	<u>PERSONAL</u>
Arthritis	_____	_____			
Osteoporosis	_____	_____	Seizures/Epilepsy	_____	_____
High Blood Pressure	_____	_____	Kidney/Bladder Problems	_____	_____
Heart Disease	_____	_____	Chronic Fatigue	_____	_____
Heart Attack	_____	_____	Frequent Headaches	_____	_____
Pacemaker	_____	_____	Organ Transplant	_____	_____
High Cholesterol	_____	_____	Low Testosterone	_____	_____
Liver Disease	_____	_____	Asthma	_____	_____
Diabetes	_____	_____	Fibromyalgia	_____	_____
Anemia	_____	_____	Polycystic Ovaries (PCOS)	_____	_____
Depression	_____	_____	Recent Weight Loss/Gain	_____	_____
Anxiety	_____	_____	Thyroid Problems	_____	_____
Cancer	_____	_____	Obesity	_____	_____

Other: _____

If you answered "yes" to any of the above, please explain below: _____

FOR OFFICE USE ONLY: VERIFY ADDRESS? **YES NO** VERIFY CONTACT PHONE NUMBER? **YES NO**

VERIFIED ON: ____/____/____ BY _____ (STAFF INITIALS)



Please list any and all surgeries (including cosmetic) and the dates: _____

Please list any complications to the surgeries, if any: _____

Name of your Primary Care/Family Physician: _____

Date of your last physical examination: _____

Physical Exams

Do you have a physical examination done yearly? YES / NO

Does your physical exam include a PAP test and a mammogram *if* recommended? YES / NO

Do you use Birth Control? YES / NO If yes, what form? _____

Is there any chance you might be pregnant? YES / NO

Other Physicians you see: _____

***The information above is correct to the best of my knowledge:

PATIENT SIGNATURE (Parent/Guardian Signature)

____/____/____
Date





ARIZONA MEDICAL
Weight Loss
 Gary A. Knighton, D.O.

2152 S. Vineyard · Suite 135 · Mesa, AZ 85210

PATIENT'S **LEGAL** NAME

FIRST: _____ MIDDLE: _____ LAST: _____

DATE OF BIRTH: ____/____/____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIPCODE: _____

PHONE (CELL): (____) ____-____ (ALTERNATE NUMBER): (____) ____-____

E-MAIL ADDRESS: _____

GENDER: MALE FEMALE SINGLE / MARRIED / DIVORCED / WIDOWED

PERSON(S) WE MAY CONTACT IN CASE OF EMERGENCY: *****(YOU MUST LIST AT LEAST ONE)*****

NAME: _____ PHONE #: (____) ____-____

NAME: _____ PHONE #: (____) ____-____

HOW DID YOU HEAR ABOUT OUR OFFICE? (CIRCLE ALL THAT APPLY)

FRIEND/FAMILY (PLEASE LIST THEIR FIRST & LAST NAME): _____

INTERNET

DOCTOR: _____

OTHER (PLEASE EXPLAIN): _____



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I, _____, CERTIFY THAT I AM NOT PREGNANT AT THIS TIME,
(PLEASE PRINT: FIRST & LAST NAME)

AND IF I DO BECOME PREGNANT, I WILL IMMEDIATELY NOTIFY DR. KNIGHTON.

PATIENT SIGNATURE

___/___/___
DATE

WITNESS

___/___/___
DATE





Financial Policy

Payment is due at the time of treatment. Unfortunately, we **DO NOT** accept checks. We DO accept the following: Debit cards, Visa, MasterCard, American Express, Discover and cash.

Dr. Knighton does not accept any insurance, nor does he bill insurance for any treatment rendered by this office. I agree that I am responsible for the charges in full for services rendered at the time they are rendered.

No Show Appointments: A 24 hour notice is requested if you need to change an appointment. If you simply do not show for your appointment, a minimum of **\$25** will be accessed to your account.

Medical Forms/Letters: There is a \$50 charge for any letters or forms that Dr. Knighton has to complete. This includes anything that may be needed for HSA accounts or health insurance.

I agree to pay all finance charges, billing charges and all collection fees that may be incurred to collect any balance that may be owed.

Please note that there are no refunds once payment is rendered for services. If you elect to discontinue a pre-paid service, the remaining balance will be evaluated by Dr. Knighton and the unused portion may be applied toward a different service or services.

Patient Signature (parent/guardian if minor)

____/____/____
Date

