ARIZONA MEDICAL Weight Loss
Gary A. Knighton, D.O.
2152 S. Vineyard · Suite 135 · Mesa, AZ 85210

Patient History Form (MALE)

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?

	FAMILY	PERSONAL		FAMILY	PERSONAL
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	_____	_____	Recent Weight Loss/Gain	_____	_____
Depression	_____	_____	Thyroid Problems	_____	_____
Anxiety	_____	_____	Obesity	_____	_____
Cancer	_____	_____	ADD/ADHD	_____	_____
Bipolar	_____	_____			
Schizophrenia	_____	_____			

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:_____

_____

Physical Exams

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

Did your physical include a prostate exam? YES / NO

Date of your last physical examination:_____

Primary Care Physician:_____

Other Physicians you see:_____

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

_____ _____/_____/_____

PATIENT SIGNATURE (Parent/Guardian Signature) Date

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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):_____

OFFICE USE ONLY: NEW PATIENT RESTART (MONTH & YEAR):_____/_____ UPDATED INFO DL COPIED/VERIFIED?_____ DATE:_____/_____/_____ STAFF INITIALS:_____

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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 **$50** will be accessed to you account.

Medical Forms/Letters: There is a **$75** 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