5362 South 72nd Street
Ralston, NE 68127
402.315.3600

Modern MEDICINE

PATIENT INFORMATION FORM

Patient Name:(Last)_____ (First)_____ (MI)_____

Name you prefer to be called:_____

Patient Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____

Email:_____

Birthdate:_____ Age:_____ Sex: M F

Employment Information:

Patient Employer:_____ Occupation:_____

Work Phone No:_____ Ext. _____

Social Security:_____ Drivers License: _____

In Case of Emergency:

Name: Relationship:_____ Phone: _____

Family Physician:_____ Phone: _____

How Did You Hear About Us? (*Please circle or identify where necessary)

Direct Mail Radio Friend Brochure TV Internet

If Referred, By Whom:_____

Financial Policy:

Thank you for selecting Modern Medicine for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Discover, and Care Credit. The purchase of our weight management program is non-refundable. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date

Patient Medical History Form

Patient Name:_____ Age:_____ Sex: M F

Present Status:

Are you in good health at the present time to the best of your knowledge? Yes No
Explain a "no" answer:

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Are you under a doctor's care at the present time? Yes No
If yes, for what?

Are you taking any medications at the present time? Yes No

Prescription Drugs: (*List all) Yes No

Drug: Dosage:

_____
_____
_____
_____
_____
_____

Over-the-Counter Medications, Vitamins, Supplements: (*List all) Yes No

Product: Dosage:

_____
_____
_____
_____
_____
_____

Past Medical History: (*check all that apply)

_____Polio
_____Jaundice
_____Kidneys
_____Lung Disease
_____Rheumatic Fever
_____Ulcers
_____Anemia
_____Tuberculosis
_____Drug Abuse
_____Pneumonia
_____Cholera
_____Arthritis
_____ Diabetes
_____ Heart Attack /Heart Disease

_____Measles
_____ Mumps
_____Scarlet Fever
_____Whooping Cough
_____Bleeding Disorder
_____Gout
_____Heart Valve Disorder
_____Gallbladder Disorder
_____Eating Disorder
_____Malaria
_____Cancer
_____ Osteoporosis
_____Hypertension
_____Blood Transfusion

_____Tonsillitis
_____Pleurisy
_____Liver Disease
_____Chicken Pox
_____Nervous Breakdown
_____Thyroid Disease
_____Heart Disease
_____Psychiatric Illness
_____Alcohol Abuse
_____Typhoid Fever
_____Blood Transfusion

Serious Injuries: (*Only if it effects ability to exercise) Yes No

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Specify (*List all): Date:

Any Surgery: (*Major surgeries only) Yes No

Specify (*List all): Date:

History of Sleep Apnea: Yes No

Any Allergies to Any Medications? Yes No

Specify: (*List all):

_____

_____

_____

Family History: (*Only as it relates to obesity)

	AGE	HEALTH	DISEASE	CAUSE OF DEATH	OVERWEIGHT?
FATHER					
MOTHER					
BROTHERS					
SISTERS					

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WEIGHT LOSS PROGRAM CONSENT FORM

I_____ authorize Dr. Mike Luft and whomever they designate as their assistant, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medication. Other treatment options may include may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for duration exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and success fully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand there are certain health risks associated with remaining overweight or obesity. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack, and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment if, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ Time:_____

Witness: _____ Patient:_____

(Or person with authority to consent for patient)

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PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

Procedures and Alternative

I,_____ (patient or patient's guardian), I authorize Dr. Mike Luft to assist me in my weight reduction efforts. I understand my treatment may involve, but not limited to, the use of appetite suppressant for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

I have read and understand my doctor's statements that follow:

Medications, including the appetite suppressant have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

As a bariatric physician, I have found the appetite suppressant helpful for periods far excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a Physician, I am not required to use the medication as the labeling suggestions, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer terms studies, and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, increase doses.

Such usage has not been as systematically studied as that suggested in the labeling and it is possible as with most other medications, that there could be serious side effects (as noted below).

As a bariatric Physician, I believe the probability of such side effects is outweighed by the benefits of the appetite suppressant use for longer periods of time and when indicated in increased doses. However you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressant use in this manner may give.

I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressant.

_____ _____

Patient's Signature Date