PATIENT REGISTRATION

First Name: Last Name:

Date of Birth: Gender: M / F Email:

Street Address: Suite / Apt #::

City: State: Zip:

Home Phone: Cell Phone:

EMERGENCY CONTACT

Friend / Relative:

Home Phone: Cell Phone:

PRIMARY PHYSICIAN

Name:

Phone: Date of Last Physical:

CONTINUE

Continue by completing your Health History on the next page.

About Your Health

Conditions

Please list any medical conditions that you have now or have had in the past (ex. migraines, anxiety, depression, cancer, etc.).

List Medical Conditions:

Allergies

Please list anything that you are allergic to. List both food and medicine allergies.

List Food / Medicine Allergies:

Medications

Please list all medications (prescription and over-the-counter) and supplements that you take. Tell us the strength and how often you take them.

List Medications / Supplements:

Surgeries

Tell us about any surgeries you have had.

List your surgeries:

Behavior

Have you tried to diet in the past 12 months? **Y / N**

Rank your sweets/sugar intake. **High / Medium / Low**

How much salt do you use? **Alot / Some / Rarely**

How much caffiene do you drink? **Alot / Some / Rarely**

Are you typically nervous or anxious in everyday life? **Yes / Sometimes / Never**

Are you pregnant, trying to get pregnant, or breastfeeding? **Yes / No**

How often do you drink alcohol? **Never / Sometimes / Daily**

Is your spouse overweight? **Yes / No**

Notice of Information Practices and Privacy Statement

AmeriThin Inc.
1210 Hillcrest Road
Mobile, AL 36695

How We Collect Information About You: AmeriThin Inc. and its subsidiaries (ATI) and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between ATI and health care providers, medical product or service providers, pharmacies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you receive care from us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

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Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

Patient Signature: **Date:**