Pennington Med Spa, LLC
Skin care, Laser & Weight Loss Clinic

~PATIENT INFORMATION~

(PLEASE PRINT)

Last Name First Name Middle Initial

Cell Phone ( )

Address

Home Phone ( )

City

State ZIP

Male/Female

Sex (Circle) Age Birthdate (Mo/Day/Year) / /

Email

Patient Employer

Occupation

Employer Address

Whom may we thank for referring you?

In case of emergency who should be notified?

Emergency Contact's Address

Emergency Contact's Phone

Weight Loss Patients Only

Weight: Current Heaviest Lowest

Clothing Size: Current Largest Smallest

Weight loss results vary among patients and are not guaranteed

Have you ever participated in other weight loss programs?_________________ Which ones? ____

Have you ever taken appetite suppressants?____________ Which ones?____________________________ Please list any negative side effects you experienced

____

What is your ideal weight goal? _________________ Clothing size goal?________________ Current Activity Level____

Have you ever had lipo?____________________ When?________________________ Tummy Tuck?________________________ When?_____________________

Have you ever had bariatric surgery?________________ When?________________ What type?____

Acknowledgement of Receipt of Notice of Privacy Practices

Please Note: A copy of our Notice of Privacy Practices (HIPPA) is attached for your reading and review. Please read and sign below acknowledging receipt there of.

Please let us know if you would like a paper copy of this notice for your personal files. You may also obtain a copy on our website: CrawfordMedSpa.com

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Crawford Med Spa and Transformation Weight Loss Clinic.

Signature:____ Date:_________________________