7734 Nashville St. Ringgold, GA 30736

Patient Information Form

Patient Name: _____

Name you prefer to be called: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____ Sex: M or F SSN: _____

Spouse: _____ Phone: _____

If patient is a minor, please complete the following:

Child lives with ____ Mother ____ Father ____ Both ____ Other _____

Employment Information

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Work Number: _____ Ext: _____

Preferred Contact Number: _____ Home _____ Work _____ Cell

Patient Signature: _____ Date: _____

In Case of Emergency

Person to Contact: _____

Phone: _____ Relationship: _____

Family Physician: _____

Address: _____

Phone: _____ Fax: _____

Whom may we thank for referring you today? _____

(Billboard, Internet, Newspaper, Magazine, Friend, Commercial, Expo or Show)

Insurance Information

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Type: HMO PPO Other .

Policy Number: _____ Effective Date: _____

Relationship to Patient: _____

Policy Holders Name: _____ D. O. B. _____

**Please allow us to make a copy of your insurance card in the event we need to refer you to a specialist. Thank you.

**We also need to make a copy of your driver's license for our records.

Financial Policy

Millennium Medical & Weight Loss Center would like to welcome you and Thank You for choosing our practice for your healthcare. We would like to take this time to explain our financial policies. Unfortunately, in this day and age many services we provide may not be covered by your insurance carrier. We are here to provide you with the best possible healthcare. **Your insurance is a contract between you and your employer and/or the insurance company.** While we may be a provider of services, we are not a part of the contract that you have with your insurance provider. Our office does not accept insurance at this time. However, we can give you an itemized receipt to submit to your insurance company for reimbursement. We do accept Flex spending account cards and can also give you a receipt for your services to submit to your employer if needed. For your convenience we accept Visa, MasterCard, Discover, and cash as forms of payments. No checks are accepted in our office. In order to help serve you most effectively, we need your assistance and understanding of our financial policy.

1. Payment is required at time of services. If for some reason you are unable to pay in full at your time of service you may be charged an additional fee of $10.00 unless other arrangements have been previously made.
2. Missed scheduled appointments will be charges a No-Show fee of $25.00 if not canceled within 24 hours.
3. If you require a copy of your labs, or any diagnostic test, please request this in writing and provide us with a self addressed stamped envelope. Otherwise these documents will be available for your pick up with 24 hours notice given to the office.
4. All forms and applications such as SCHOOL FORMS or LETTERS that require a physician's time to complete will be charged a $15.00 fee if not completed during a routine office visit.
5. There will be a fee to copy medical records. Please allow up to 30 days upon receipt of a signed consent form.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, THAT ANY QUESTIONS HAVE BEEN FULLY EXPLAINED, AND THAT HE/SHE UNDERSTANDS THE CONTENTS. THE UNDERSIGNED HEREBY AGREES TO ALL TERMS SET FORTH IN THIS DOCUMENT.

Print Patient Name: _____ DOB: _____

Sign Patient/Guardian Name: _____ Date: _____

Witness: _____ Date: _____

Effective date of this notice: March 1, 2011

Millennium Medical & Weight Loss Center

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Probability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET THE ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your ***Individually Identifiable Health Information*** (IHII). In conducting our business, we will create records regarding you and the treatment of services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning you IIHI. By federal and state law, we must follow the terms and notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Millennium Medical and Weight Loss Center, LLC **Attn: Office Manager**
7734 Nashville St.
Ringgold, GA 30736
Phone: 706-937-2099 Fax: 706-937-4062
info@millmedweightloss.com

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **TREATMENT** Our practice may use you IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including, but not limited to, our doctors, nurses, medical assistants, and/or front desk receptionist- may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to other who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. **PAYMENT** Our practice may use your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose you IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **HEALTH CARE OPERATIONS** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. **APPOINTMENT REMINDERS** Our practice may use and disclose your IIHI to contact you and remind you of an appointment. We may call and leave a message on your answering machine or with a family member as a reminder of your appointment.
5. **TREATMENT OPTIONS** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. **HEALTH-RELATED BENEFITS AND SERVICES** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

7. **RELEASE OF INFORMATION TO FAMILY/FRIENDS** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the physician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. **DISCLOSURES REQUIRED BY LAW** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **PUBLIC HEALTH RISKS** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect
    - Preventing or controlling disease, injury or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Notifying a person regarding potential risk for spreading or contracting a disease or condition
    - Reporting reactions to drugs or problems with products or devices
    - Notifying individuals if a product or device they may be using has been recalled
    - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required by law to disclose this information
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. **HEALTH OVERSIGHT ACTIVITIES** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and health care system in general.
3. **LAWSUITS AND SIMILAR PROCEEDINGS** Our practice may use and disclose your IIHI in response to court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **LAW ENFORCEMENT** We may release IIHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe has resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena or similar legal process
    - To identify/locate a suspect, material witness, fugitive or missing person
    - In an emergency, to report a crime (including the locations of the victim(s) of the crime, or the description, identity or location of the perpetuator)

OPTIONAL:

5. **DECEASED PATIENTS** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:

6. **ORGAN AND TISSUE DONATION** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:

7. **RESEARCH** Our practice may use and disclose your IIHI for research purposes I certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers a~ the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHY will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.
8. **SERIOUS THREATS TO HEALTH OR SAFETY** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **MILITARY** Our practice may disclose your IIHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **NATIONAL SECURITY** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized my law. We also may disclose your IIHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.
11. **INMATES** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **WORKERS COMPENSATION** Our practice may release your IIHI for worker's compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **CONFIDENTIAL COMMUNICATIONS** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to: **Office Manager, email: info@millmedweightloss.com or fax (706) 937-4062 or in person in the office at 7734 Nashville St., GA 30736** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. **REQUESTING RESTRICTIONS** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do not agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make a request in writing to: **Office Manager, email: info@millmedweightloss.com or fax (706) 937-4062 or in person in the office at 7734 Nashville St. Ringgold, GA 30736.** Your request must describe in a clear and concise fashion:
   (a) The information you wish restricted
   (b) Whether you are requesting to limit our practice's use, disclosure or both; and
   (c) To whom you want the limits to apply
3. **INSPECTION AND COPIES** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and medical billing records, but not including psychotherapy notes. You must submit your request in writing to: **Office Manager, email: info@millmedweightloss.com or fax (706)937-4062 or in person in the office at 7734 Nashville St. Ringgold, GA 30736 in order to inspect and/or obtain a copy of your IIHI.** Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **AMENDMENT** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: **Office Manager, email: info@millmedweightloss.com or fax (706)937-4062 or in the office at 7734 Nashville St. Ringgold, GA 30736.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is our

opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **ACCOUNTING DISCLOSURES** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request your request in writing to: **Office Manager, email: info@millmedweightloss.com or fax (706)937-4062 or in the office at 7734 Nashville St. Ringgold, GA 30736.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before May 25, 2009. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **RIGHT TO PAPER COPY OF THIS NOTICE** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: **Office Manager, email: info@millmedweightloss.com or fax (706)937-4062 or in the office at 7734 Nashville St. Ringgold, GA 30736.**
7. **RIGHT TO FILE A COMPLAINT** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: **Office Manager, email: info@millmedweightloss.com or fax (706)937-4062 or in the office at 7734 Nashville St. Ringgold, GA 30736.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
8. **RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time **in writing.** After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again if you have any questions regarding this notice or our health information privacy policies, please contact: Office Manage, email: info@millmedweightloss.com or fax (706)937-4062 or in the office at 7734 Nashville St. Ringgold, GA 30726- office phone (706)937-2099.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed a copy of

(Print Patient's Name)

Millennium Medical & Weight Loss Center, LLC's Notice of Privacy Practices.

_____ DOB_____ Date_____

Signature of Patient/Guardian

I, _____, authorize Millennium Medical

Signature of Patient/Guardian

and Weight Loss Center to leave normal lab results on my home answering machine.

I, _____, authorize Millennium Medical

Signature of Patient/Guardian

& Weight Loss Center to leave medical information regarding myself with

_____. Relationship: _____

I, _____, DO NOT wish to have

Signature of Patient/Guardian

messages left on my home answering machine.

PATIENT AUTHORIZATION FORM

The undersigned patient authorizes Millennium Medical & Weight Loss Center at 7734 Nashville St. Ringgold, GA 30736 to act as my agent for the purpose of ordering and receiving my prescription for:

_____ (initials)

I understand that Millennium Medical & Weight Loss Center will be financially responsible to the pharmaceutical company for payment of the prescription(s) related to this authorization. _____ (initials)

The undersigned further agrees to reimburse Millennium Medical & Weight Loss Center for prescriptions ordered and received from pharmaceutical companies. _____ (initials)

Patient Name: _____ D.O.B.: _____

Signature: _____ Date: _____

Witness: _____

This form is for records of ordering injectable medications such as HCG, B12, or Lipo B. If any questions please ask our front desk receptionist.

Millennium Medical & Weight Loss Center

7734 Nashville St. Ringgold, GA 30736

Phone: 706-937-2099 Fax: 706-937-4062

MillMedWeightLoss.com

"Lose Weight & Be Healthy"

Weight Loss Program Consent Form

I, _____ authorize Millennium Medical & Weight Loss Center and whomever they designate as their assistants, 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 medications. Other treatment options 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 durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully 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 that there are certain health risks associated with remaining overweight or obese. 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 even 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 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 explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read understand this form.

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

PLEASE NOTE: Signing this form in no way obligates you to participate in the program.

Date: _____ Time: _____

Patient: _____ Witness: _____
(Or person with authority to consent for patient)

Medical History Form

Name: _____ Age: _____ Sex: M F .

Family Physician: _____ Phone: _____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? _____
3. Are you taking any medications at this present time?
   Medication: _____ Dosage: _____
   Medication: _____ Dosage: _____
   Medication: _____ Dosage: _____
4. Any allergies to any medications? Yes No
   If yes, which one(s)? _____
   Any other allergies? _____
5. History of High Blood Pressure? Yes No
6. History of Diabetes? Yes No
   At what age? _____
7. History of Heart Attack or Chest Pain? Yes No
8. History of Swelling Feet Yes No
9. History of Frequent Headaches? Yes No
   Migraines? If so, what medications: _____ Yes No
10. History of Constipation? Yes No
11. History of Glaucoma? Yes No
12. Gynecologic History:
    Pregnancies: _____ Dates: _____
    Natural Delivery or C-Section (specify): _____
    Menstrual: Onset: _____ Duration: _____
    Are they regular? (every 28 days) Yes No
    Pain Associated? Yes No
    Last Menstrual Period? _____
    Hormone Replacement Therapy: Yes No
    If so, what medications: _____
    Birth Control Medication: Yes No
    Type of Medication: _____
    Date of last Pap Smear: _____

Nutrition Evaluation:

1. Present Weight: _____ Height: (without shoes) _____ Desired Weight: _____
2. In what time frame would you like to be at your desired weight? _____
3. Weight at age 18: _____ Weight at age 30: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____
5. Do you awaken hungry during the night? Yes No
   If so, what do you do? _____
6. Do you wake up in the morning hungry? Yes No
   What do you eat for breakfast? _____
7. What time of day are you the hungriest? _____
8. Do you eat/snack after your evening/dinner meal? Yes No
   If yes, how much do you eat? _____

9. When/What meal do you eat the most of your calories? _____

10. Activity Level: **ANSWER ONLY ONE**

_____ Inactive: No regular physical activity with a sit-down job
_____ Light Activity: No organized physical activity during leisure time
_____ Moderate Activity: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____ Heavy Activity: Consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling, or active sports at least three times per week.
_____ Vigorous Activity: Participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Past Medical History

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____ Ulcers	_____ Gout	_____ Thyroid Disease
_____ Anemia	_____ Heart Disease	_____ Heart Valve Disorder
_____ Tuberculosis	_____Psychiatric Illness	_____ Gallbladder Disorder
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Pneumonia	_____ Malaria	_____ Typhoid Fever
_____ Cholera	_____ Cancer	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ Other: _____

I certify that all of the above information is true to date to the best of my knowledge.

Patient Name: _____ Date: _____

Patient Signature: _____