

REYNOSO MD

Medical Weight Loss Center

hCG Registration Form

(PLEASE PRINT)

Client Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip code _____

Marital Status: Single Married Divorced Separated Widowed Significant Other

Social Security Number _____ Sex: Female Male

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

Cell Phone _____ Secure Email Address _____

Emergency Contact Name _____ Phone _____

Do you wish to receive e-mails of our newsletter or information related to our practice? Yes No

Primary Care Physician's Name _____ Phone _____

How were you referred to our office? _____

How did you hear about the hCG Weight Loss Program? _____

Have you attempted to lose weight before? Yes No Most pounds lost? _____ How long it took? _____

Describe what other weight loss programs/methods have you tried (ex: diets, pills, etc.) and your results:

Have you ever stayed the same weight for 10 years or more? Yes No

What was your lowest weight? _____ Your age then? _____ How many years ago? _____

What was your highest weight? _____ Your age then? _____ How many years ago? _____

Your present weight? _____ Your goal weight? _____ Your height? _____

How many times a day do you eat? _____ Do you snack? _____ Do you eat sweets? _____

Why do you want to lose weight now? _____

What is your most important reason for losing weight? _____

Please make any comments that you think might be helpful _____

Client Signature _____

Date _____