Integrative, LLC Weight Loss Program
10404 W. Coggins Dr. ste#118
Sun city, AZ 85351
Phone: (623) 972-1055
Fax: (623) 972-1185

Patient Registration Form

Today's Date: _____

Patient information

Date of birth: _____
Patient's name: (Last) _____ (First)_____

Age_____ Height_____ Weight_____ Sex: M____ F ____

Street Mailing Address:

_____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____

How did you hear about us

Clinic because/referred to clinic by: Doctor. ____ Current Client:____ Walk-In:____

Family Friend:____ Close to home/work:____ Internet:____ Other:_____

Case of emergency

Name of local friend or relative: _____

Relationship to patient: _____

Home phone: (_____) _____ Cell phone: (_____)_____

Medications

Current medications & dosages:_____
_____
_____
_____
_____
_____
_____
_____

Do you have any Allergies to medications? ____ Yes ____ No
If so which drugs: _____

Financial Policy

Thank you for choosing. Dr. Anita Dai for your Weight Loss needs provider. We are honored to be of service to you and your family. Above information is true to the best of my knowledge. I understand that I am financially responsible for any balance owed. I understand my insurance doesn't cover any part of The Weight Loss Program.

Sign: _____ Date: _____