2325 Timber Shadows Dr, Suite B
Kingwood, TX 77339
832-995-3380

Registration Form

Date: _____

Name: _____ DOB: _____ AGE: _____ ☐M ☐F

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____ Preferred Language: _____

Primary Provider Name: _____ Office Location & Phone: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Initial and Sign Below

_____Release of Protected Health Information: I hereby authorize The Med Spa of Kingwood (MSK), and its affiliates("Providers") to release acquired in the course of my treatment to my insurance, employer-based health plan, third-party payer as required of claims filed, quality assurance, health plan admin, complaints, grievances and to negotiate my claims on my behalf.

_____Financial Agreement: I understand and agree that all services provided by The Med Spa of Kingwood must be paid for on the same day the services are rendered. The accepted payment methods are cash or credit card. No insurance claims will be filed for any services rendered at The MSK.

_____ Payment Responsibility: I am responsible for the full payment of all services received at The MSK, including any additional fees or charges incurred during the course of treatment.

_____ Fees & Charges: I acknowledge that I will be informed of all fees and charges associated with the services before they are rendered. I agree to pay these fees in full on the same day the services are provided.

_____ Refund Policy: I understand that all payments made for services at The MSK are nonrefundable. In case of any disputes or concerns regarding charges, I agree to address them directly with The MSK management team.

☐ I have read and understand the initial statements; the above information I provided is true to the best of my knowledge.

Patient Signature: _____DATE: _____

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Medical Weight Loss Program Intake Form

Date: _____

Name: _____ DOB: _____ AGE: _____ ☐M ☐F

Height: _____ Weight: _____ Goal Weight:_____ Last Menstrual Period:_____

Allergies: ☐None ☐Penicillin ☐Sulfa ☐Iodine ☐Codeine ☐Latex ☐Nuts Other: _____

What Weight Loss Program are you interested in today?
☐ Semaglutide ☐ Tirzeptide ☐ Phentermine ☐ Sermorelin

Have you ever been on a Medical Weight Loss Program before? ☐Y ☐ N
If Yes, which program? _____

Medical History: Select Y or N

	Y	N
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Hyperthyroidism	☐	☐
Medullary Thyroid Cancer	☐	☐
Multiple endocrine neoplasia, type 2	☐	☐
Glaucoma	☐	☐
ADHD or Bipolar Disease	☐	☐
Diabetes	☐	☐
Prediabetes	☐	☐
COPD/ Asthma	☐	☐
Sleep Apnea	☐	☐
Current Pregnancy or Breastfeeding	☐	☐
Hypothyroidism	☐	☐
Pancreatitis	☐	☐
Migraines	☐	☐

OTHER: Click or tap here to enter text.

Medications: Please list all current prescribed medication and over-the-counter supplements you take on a regular or daily basis
_____

Past Surgical History : (please check all that apply)

☐ Tonsillectomy ☐ Hernia Repair
☐ Cholecystectomy ☐ C-Section
☐ Appendectomy ☐ Gastric Bypass
☐ Vasectomy ☐ Hysterectomy ☐ Other: _____

Family History: _____

Social History:
Smoker: ☐Y ☐N ____ppd, Illicit Drugs: ☐Y ☐N Alcohol Use: ☐Y ☐N ___drinks per day/week

Patient Signature: _____ **Date**_____