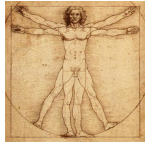


BIANCHI MEDICAL WEIGHT LOSS CENTER, LLC



ALEX BIANCHI, D.O., ABBM, ABFP
5936 LIMESTONE ROAD SUITE 202
HOCKESSIN, DE 19707

PATIENT DEMOGRAPHIC SHEET

*** PATIENT INFORMATION ***			
PATIENT LAST NAME:	FIRST:	MI:	DATE OF BIRTH:
ADDRESS:		APT #	HOME PHONE #: ()
E-MAIL ADDRESS:	SOCIAL SECURITY #		CELL PHONE #: ()
*** EMERGENCY CONTACT INFORMATION ***			
LAST NAME:	FIRST:	RELATION TO PATIENT:	PHONE # ()
*** HOW DID YOU HEAR ABOUT US??? ***			
<input type="checkbox"/> FRIEND <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> TELEPHONE BOOK <input type="checkbox"/> PHYSICAL THERAPIST <input type="checkbox"/> WEBSITE <input type="checkbox"/> HEALTH CLUB <input type="checkbox"/> PHYSICIAN (DR. _____) <input type="checkbox"/> OTHER _____			
PHYSICIAN/SPECIALIST INFORMATION			
PRIMARY CARE PHYSICIAN _____ SPECIALISTS _____			

Please read and initial the following:

_____ I agree to pay the 6-month program fee of \$675 due prior to my first appointment. This fee will include seven (7) office visits, all patient education materials, lab work, and one EKG during the first visit.

_____ I understand that any further maintenance program and/or office procedures will have a separate fee.

_____ I understand that if medications and/or lab work is prescribed; this may not be covered/paid for by my insurance company.

_____ I agree to NOT reproduce any educational materials for use other than for my own diet program.

_____ ***I UNDERSTAND THAT IF I MISS ANY OF MY SCHEDULED APPOINTMENTS I WILL BE AUTOMATICALLY DISCHARGED FROM THE PROGRAM WITHOUT REFUND***

Payment Method
<input type="checkbox"/> Cash: \$675 (includes pre- and post-lab work)
<input type="checkbox"/> Credit Card: _____ exp date: _____
<input type="checkbox"/> Payment Plan (credit only): <input type="checkbox"/> \$400 Due at 3 rd visit: <input type="checkbox"/> \$375

Patient Signature _____ Date _____