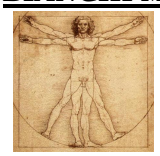
BIANCHI MEDICAL WEIGHT LOSS CENTER, LLC



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??? ***

☐ FRIEND ☐ NEWSPAPER ☐ TELEPHONE BOOK
☐ PHYSICAL THERAPIST ☐ WEBSITE ☐ HEALTH CLUB

☐ PHYSICIAN (DR. _____)
☐ 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.

Payment Method
☐ Cash: $675 (includes pre- and post-lab work)
☐ Credit Card: _____ exp date: _____
☐ Payment Plan (credit only): ☐ $400 Due at 3rd visit: ☐ $375

_____ 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 that for my own diet program.

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

Patient Signature _____ Date _____