AIM Weight Management
2200 Northern Boulevard, Suite 133
East Hills, NY 11548
(Tel) 516-352-8100
(Fax) 516-352-7348

Dear New Patient,

We welcome you to our practice and look forward to a long and healthy relationship.

As you may know, our practice concentrates on very personalized care for each and every patient. AIM Weight Management is known for the time given to each patient to address their individual needs. Overall wellness and quality of life are our primary goals.

In order to help us achieve these goals, please complete the enclosed paperwork and fax back to (516) 352-7348, prior to your scheduled visit.

PLEASE REMEMBER TO BRING YOUR INSURANCE CARD ON THE DAY OF YOUR VISIT SO THAT WE MAY HAVE A COPY FOR OUR RECORDS.

Should you have any additional questions or concerns please do not hesitate to call our office, our staff is available to assist you in any way possible.

Sincerely,

Dr. Craig Grobman &

Jenne O'Neill, NP-BC

AIM Weight Management

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Please take a few minutes to complete these forms and fax them back to us prior to your scheduled visit, at (516) 352-7348. This information will assist us in better understanding your lifestyle, goals, and preferences, and will help to guide us in developing your individualized plan. Thank you.

General Patient Information

Today's Date: ___/___/_____ DOB: ___/___/_____

Name: _____ _____
Last First

Phone Number: _____ Email: _____

Address: _____ City: _____ Zip Code:_____

How did you hear about AIM Weight Management? _____

Name of Primary Care Provider: _____

Date of last Annual Wellness visit: _____

- Have you received an EKG in the past 6 months? Y / N (If so, please bring a copy if possible)
- If over one year, would you like to receive a complete Wellness Visit? Y / N

Pharmacy Information

Name of Pharmacy _____

Address _____

Phone # _____

Emergency Contact Information

Name _____ Relation _____

Address _____

Phone # _____

Eating Habits

On average, how many home prepared meals do you eat per week?

Breakfast _____ Lunch _____ Dinner_____

On average, how many restaurant (sit down, fast food, take-out) prepared meals do you eat per week:

Breakfast _____ Lunch _____ Dinner_____

Do you use meal replacements (e.g. snack bars or shakes)? Y / N

If so, how many times per week?

Breakfast _____ Lunch _____ Dinner_____

Types of restaurants I frequent are:

Fast Food (McDonald's, Wendy's, Taco Bell) Y / N

Fast "Fresh" Food (Deli, Panera, Subway) Y / N

Sit Down (Italian, Mexican, Sushi) Y / N

On average, how many *snacks* (including "picking") you eat in a day? _____

How would you rate the nutritional content of your overall diet?

☐ Excellent ☐ Good ☐ OK ☐ Poor

How creative would you say you are at meal planning?

_____ Very. I love new recipes and am *always* trying something new

_____ Somewhat. I try new recipes / dishes once or twice a *week*

_____ OK. I try new recipes dishes once or twice a *month*

_____ I'm not. I stick to a generally fixed rotation of meals

How conscious are you when planning a meal to include various food groups (proteins, vegetables, grains, starches)?

☐ I give it a lot of thought ☐ I try to consider it ☐ I just put a few things on a plate

Do you find that you often crave sweets? Y / N

If so, at what point during the day?

☐ Morning ☐ Mid-Day/Lunch ☐ Late Afternoon (3-4PM) ☐ Evening (dinner or after)

What time of day do you generally eat your last/latest meal/snack? _____

What types of beverages do you typically drink?

☐ Coffee/Tea ☐Water ☐ Flavored Water/Electrolyte Drinks

☐ Soda/Carbonated Drinks ☐ Alcohol ☐ Juice

Activity

On average, how many hours of *uninterrupted* sleep do you get each night? _____

Do you use a fitness or "step tracker" (Fit Bit, Garmin, Apple Watch)? Y / N

Do you exercise regularly? Y / N

If so, how many days each week? _____

How many minutes each time? ☐ 10 to 20 minutes ☐ 30 to 45 minutes ☐ 60 or more minutes

What types of exercise do you prefer?

☐ Walking ☐ Jogging / Running ☐ Bicycle

☐ Gym / Lifting weights ☐ Yoga / Tai Chi ☐ Other

Weight Loss / Management History

Do you have a history of an eating disorder? Y / N

Have you tried dieting / losing weight in the past? Y / N

If yes, which plans / methods have you tried?

☐ Calorie Counting ☐ Exercise alone ☐Weight Watchers

☐ Nutrisystem ☐ Medication ☐ Other

Were you successful in losing weight? Y / N

If yes, how much did you lose? _____ pounds

Have you been successful at keeping the weight off? Y / N

If yes, for how long? _____

If the results were temporary, can you identify factors that may have contributed to regaining the weight?

Of the diets or weight loss plans you have tried, what were some of the qualities that you liked / didn't like?

Liked / Worked for me	Didn't like / Didn't work for me
_____	_____
_____	_____
_____	_____

Planning and Setting Goals

What can we help you to accomplish? (Select all that apply)

☐ Weight Loss ☐ Feel more energetic ☐ Learn healthier eating habits

☐ Decrease blood sugar ☐ Decrease blood pressure ☐ Decrease cholesterol

☐ Eliminate the need for some of my medications ☐ Fit into clothing comfortably

What type of Weight Loss Plan do you feel would fit into your lifestyle? (Select all that apply)

☐ Weight loss medication ☐ Calorie counting (logging/tracking) ☐ Prescribed Foods

☐ Meal Supplements (eg. bars or shakes) ☐ Food shopping / cooking at home ☐ Eating out / restaurants

☐ Increasing exercise ☐ No Exercise ☐ Exercise eventually, but not initially

☐ Daily support / accountability ☐ Weekly support / accountability ☐ Independent / Accountable to myself (and AIM Weight Management provider)

Would you be interested in receiving information about working with a Nutritional Coach or Registered Dietician (for a supplemental fee)? Y / N

Please share any additional information that you feel may be helpful in creating your plan:

_____

_____

_____

_____

_____

Medical Information and History Form

Name of Insurance Carrier:_____ **SS#:** _____-_____-_____

WOULD YOU LIKE US TO ENABLE YOU TO USE OUR PATIENT PORTAL TO ALLOW YOU TO FOLLOW YOUR MEDICAL PROGRESS? YES ☐ / NO ☐

Date	Please list any Surgeries

Date Diagnosed	Please list any Medical Conditions

Welcome to a Healthier You!

Medications with Dose and Frequency Include Over the Counter and Vitamin/Supplements		
Name	*Dose*	*Frequency (e.g. daily, as needed)*

Do you have any **Drug Allergies** (or severe reactions or side effects)?

_____

Family History-Place X in appropriate boxes and/or fill in information									
Relative	**Alive**	**Deceased**	**Age**	**Cancer**	**Diabetes**	**Heart**	**Hypertension**	**Mental Illness**	**Stroke**
Father									
Mother									
Brother									
Sister									
Son									
Daughter									

Smoking:

Do you smoke now? _____ Ever? _____

If yes, how many packs per day? _____ Year Started:_____

REVIEW OF SYSTEMS

General	No	Yes
Fever		
Chills		
Sweats/Night Sweats		
Fatigue		
Weight Gain		
Weight Loss		
HEENT		
Headaches		
Visual Changes		
Dizziness		
Nasal Discharge		
Vertigo (spinning)		
Hoarseness		
Hearing Changes		
Ear Pain		
Nose Bleed		
Ringing in the Ears		
Sore Throat		
Cardiovascular		
Chest Pain		
Shortness of Breath with exertion		
Swelling in Legs		
Palpitations		
Sudden SOB while sleeping		
Exertional Sweats		
Leg Cramps when walking		
Respiratory		
Congestion		
Shortness of Breath		
Expectoration		
Cough		
Coughing up Blood		
Shortness of Breath while lying flat		
Wheezing		
Gastrointestinal		
Abdominal Pain		
Nausea/Vomiting		
Diarrhea		
Constipation		
Change in bowel habits		
Anorexia		
Rectal Bleeding		
Vomiting Blood		
Trouble Swallowing		
Reflux		

Genitourinary	No	Yes
Sudden Urge to Urinate		
Frequent Night Time Urination		
Incontinence		
Blood in Urine		
Difficulty Urinating		
Frequency of Urination		
Painful Urination		
Musculoskeletal		
Serious Joint/Bone Injuries		
Back Pain		
Joint Stiffness		
Muscle Pain		
Painful Joints		
Swollen Joints		
Hematology		
Anemia		
Prolonged Bleeding		
Recent Transfusion		
Swollen Lymph Nodes		
Skin		
Ulcers		
Psoriasis		
Blistering of Skin		
Discoloration		
Hives		
Moles		
Nodules		
Rashes		
Neurologic		
Confusion		
Weakness		
Uncoordinated Movement		
Unbalanced		
Difficulty Speaking		
Fainting		
Headache		
Memory Loss		
Seizures		
Tingling/Numbness		
Tremors		
Psychiatric		
Agitation		
Disorientation		
Anxiety		
Hallucination		
Depression		
Insomnia		
Suicidal thoughts		

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Keeping your health information confidential and secure, and using it only as permitted by law, is a top priority of Advanced Internal Medicine Group, P.C. You have the right to know how Advanced Internal Medicine Group, P.C. uses and discloses your health information. Under the Health Insurance Portability and Accountability Act (HIPAA), Advanced Internal Medicine Group, P.C. can use your health information for Treatment, Payment and Health Care Operations. In connection with "Treatment", we may use or disclose your health information to another healthcare provider as needed for treatment. In connection with "Payment", we may use and disclose your health information to health insurers to coordinate and facilitate payment for care and services provided. In connection with "Health Care Operations", we may use and disclose your health information to assist with our business and general administrative activities related to your care management. We may also contact you by telephone to remind you of appointments.

Certain uses and disclosures that do not fall under Treatment, Payment, or Healthcare Operations will require your prior written authorization. Examples of such cases include (but are not limited to) if you would like us to send information to an employer or wish us to discuss your information with a family member.

We value our patients and the various rights afforded to them under Federal and State laws to protect health information. We recognize and will respect patients' rights to restrict the disclosure of health information when applicable. We will also accommodate patients' rights to receive confidential communications of their health information.

If you wish to receive a copy of this Notice of Privacy Practices, one will be provided. If you have any questions or concerns regarding the handling of your health information or our Privacy Practices please do not hesitate to submit them to us in writing or to contact our Practice Manager.

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PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, acknowledge that I have been offered a copy of the Notice of Privacy Practices from Advanced Internal Medicine Group P.C., and that I understand my patient rights.

_____ _____
Signature Date

_____ _____
Name (Print) Relationship to Patient (if other)

ASSIGNMENT OF BENEFITS

I authorize all payments for my medical care to be paid and sent directly to Advanced Internal Medicine Group, PC. I authorize the medical provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all of my insurance submissions, whether manual or electronic.

In the event a payment is sent directly to me, I will send both the payment and the Explanation of Benefits to Advanced Internal Medicine Group, PC within 14 days of receipt.

_____ _____
Signature Date

_____ _____
Name (Print) Relationship to Patient (if other)

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RECORDS RELEASE AUTHORIZATION

TO_____

PROVIDER OR HOSPITAL

_____

ADDRESS

I AUTHORIZE AND REQUEST THE RELEASE OF MY COMPLETE MEDICAL RECORD, INCLUDING: PATHOLOGY REPORTS, LABORATORY AND RADIOLOGY RESULTS, MEDICATION RECORDS, PAST MEDICAL HISTORY, PHYSICAL EXAM FINDINGS, PROGRESS NOTES, OPERATIVE REPORTS AND TREATMENT RECORDS TO:

AIM Weight Management

2200 Northern Blvd, Suite 133

East Hills, NY 11548

Tel 516-352-8100 Fax 516-352-7348

NAME_____ **DOB** _____

ADDRESS_____

SIGNATURE _____ **DATE**_____

RELATIONSHIP TO PATIENT_____ **WITNESS** _____

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CONTROLLED SUBSTANCES CONSENT FORM

The prescribing of any controlled substance or narcotic medication will be decided upon solely at the discretion of the medical provider. If a controlled substance is prescribed, the below terms must be followed and adhered to by the patient. Failure to comply with these terms could result in immediate termination from this practice.

- Patient agrees to take medications exactly as prescribed, and agrees to notify the medical provider if the medication is stopped, or is taken in any manner other than exactly as written by the prescriber.
- Patient agrees to keep medicine safe, secure and out of the reach of children or anyone other than the prescribed patient.
- Patient agrees to notify the medical provider if there are any changes in their health status, medical diagnoses, or if any new medications are prescribed by a provider outside of Advanced Internal Medicine Group, P.C.
- By agreeing to take medications exactly as prescribed, the patient also understands that periodic or random urine and/or blood testing may be performed without prior notification during any office visit, encounter for medical care, or at the request of the provider, to assess medication compliance and safety.
- The patient understands that all test results and their interpretation are part of their medical record; as such, patient's insurance company may discover the results of testing or obtain any other information contained in their medical record, at the request of the insurance provider.
- The patient understands that if they fail to show for scheduled visits that the medical provider reserves the right to defer or discontinue medication refills until the patient is seen and examined by an Advanced Internal Medicine Group, P.C. healthcare provider.
- The patient acknowledges and understands that lost, stolen, or misplaced prescriptions for controlled substances will NOT BE REPLACED prior to the appropriate renewal period.
- Patient is aware that if the above terms are not adhered to, the medical provider will discontinue or prescribe to taper-off medication(s), and no additional prescriptions will be provided.
- Patient understands that the risks of taking controlled substances include, but are not limited to: drug dependency and addiction; neurologic, cardiac and/or respiratory problems; depression; liver and/or kidney damage; and death.

By signing below, the patient is expressing understanding and agreement with the above terms and statements.

_____ _____

Patient (or Representative) Signature Date

_____ _____

Patient (or Representative) Name, Printed Relationship to patient (if other)

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Dear New Patient:

AIM Weight Management concentrates on very personalized care, and is known for the dedicated time given to each and every patient based on individual needs.

New Patient appointments are scheduled for at least one hour (often longer). When these appointments are cancelled without sufficient notice, it leaves a void in the schedule that cannot be filled. This causes delay in care for other patients and increases cost to our practice.

If an appointment for a new patient is missed or cancelled with less than one business day's notice, the patient will be responsible for a $100 charge, which is not covered by the insurance carrier. This amount reflects only a fraction of the cost and inconvenience to the practice. To assist in avoiding this, our staff will contact you prior to this time period to confirm your appointment. In the event a message or voicemail is left for a patient without a response or return call, this will represent a *confirmed appointment* on the patient's behalf.

Similarly, existing patients will be billed up to $50 for a missed appointment or a late cancellation, based on the type of appointment scheduled (e.g. follow-up, quarterly, scheduled testing).

The staff at AIM Weight Management recognizes that unpredictable situations may arise, and the enforcement of this policy will be approached with the highest level of integrity and understanding, with consideration given to individual circumstances.

Please sign below to express that you have read, understand and agree to terms listed above.

_____ _____

Signature Date

_____ _____

Name (Print) Relationship to Patient (if other)