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Patient Intake Form-MEDICAL WEIGHT-LOSS

3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

TODAY'S DATE _____ DATE NEEDED _____

PATIENT INFORMATION			
First:	Last:	M.I.:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:	SSN:	Best Phone:	
Address:	City:	State:	Zip:
Shipping Address (if different from home address):		Height:	Weight:

PRESCRIBER INFORMATION			
First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION			
Name of Insured:	Insurance Company:	ID#:	
Phone:	BIN#	PCN:	Group#

PLEASE FAX PATIENT'S FACE SHEET AND PHARMACY BENEFITS INFORMATION WITH PRESCRIPTION TO 866-495-3304

<input checked="" type="checkbox"/> MEDICAL WEIGHT-LOSS		
1	<input type="checkbox"/> Belviq	<input type="checkbox"/> 10mg Tabs
2	<input type="checkbox"/> Qysymia	<input type="checkbox"/> 3.75mg/23mg <input type="checkbox"/> 7.5mg/46mg <input type="checkbox"/> 11.25mg/69mg <input type="checkbox"/> 15mg/92mg
3	<input type="checkbox"/> Phentermine	<input type="checkbox"/> 15mg <input type="checkbox"/> 30mg
4	<input type="checkbox"/> Adipex	<input type="checkbox"/> 37.5mg <input type="checkbox"/> Tabs or <input type="checkbox"/> Caps
5	<input type="checkbox"/> Xenical	<input type="checkbox"/> 120mg
6	<input type="checkbox"/> Didrex	<input type="checkbox"/> 50mg
7	<input type="checkbox"/> Benzphetamine	<input type="checkbox"/> 50mg
8	<input type="checkbox"/> Diethylpropion	<input type="checkbox"/> 25mg or <input type="checkbox"/> 75mg ER Tabs
9	<input type="checkbox"/> Phendimetrazine	<input type="checkbox"/> 35mg Tabs or <input type="checkbox"/> 105mg Caps
10	<input type="checkbox"/> Cyanocobalamin (B12)	<input type="checkbox"/> 1000mg/mL
11	<input type="checkbox"/> Pyridoxine (B6)	<input type="checkbox"/> 100mg/mL
12	<input type="checkbox"/> Other	
13	<input type="checkbox"/> Other	

INSTRUCTIONS		

Refills <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> AUTO	Deliver To: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Prescriber's Office	<input type="checkbox"/> Patient to pick up at Pharmacy
<input checked="" type="checkbox"/> Medically Necessary: I, the undersigned, certify that the above prescribed compounded medication is medically necessary as part of my treatment for this patient. In my opinion, the medication prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition.		
Physician's Signature:	Date:	

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FAX PRESCRIPTION TO: 866-495-3304

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