Weight Management Clinic LLC
Linda Romero, M.D.
Patient Intake Form

Date _____

Name_____

DOB_____ Age_____Height_____

Address _____

City, State, Zip _____

Phone _____

Email _____

Marital Status _____

Occupation _____

Primary physician _____

Please read and check each item below:

___I understand that Dr. Romero does not provide primary care.

___I understand that there are no guarantees of a specific weight loss amount and that medical weight loss results vary between individuals depending on initial weight, medical conditions, individual responsiveness to medications, and adherence to treatment plans.

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Signed: _____