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

Date: ____________________________

Name:____________________________

DOB:_____________Weight: ________ Age: __________Height: ____________

Address: ____

City, State, Zip: ____

Phone: ____

Email: ____

Occupation: ____

Primary physician: ____

Pharmacy (required for prescriptions)
Name: ____
Address: ____
Phone Number: ____

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: ____