Living Hope
Eating Disorder Treatment Center

RETURNING PATIENT FORM

Meghan Scears, MD, PLLC

PATIENT NAME: _____ TODAY'S DATE: _____

ADDRESS VERIFICATION

Please check the appropriate box below.

☐ My address and/or personal information HAS NOT changed since my last visit.

☐ My address and/or personal information HAS changed since my last visit.

If you have indicated above that your address and/or personal information HAS changed, please update the following in the space provided.

_____

Address City State Zip

_____

Home Phone Cell Phone Work Phone

_____

Email

Preferred Contact Method (Please circle all that apply):
Home Phone Cell Phone Work Phone Email

By signing below, I verify that all information provided above is true and correct.

_____

Signature of Patient or Guardian Date

INSURANCE VERIFICATION

Please check the appropriate box below.

☐ My insurance provider and/or information HAS NOT changed since my last visit.

☐ My insurance provider and/or information HAS changed since my last visit.

If you have indicated above that your insurance provider and/or information HAS changed, please update the following in the space provided and return this form and your insurance card to us so we can make a copy to put in your file.

Insurance Provider	Phone Number	ID Number	Group Number
Provider Address	City	State	Zip
Policy Holder	Relationship		DOB (MM/DD/YYYY)
Policy Holder Address	City	State	Zip
Employer/School Name (circle one)		Phone Number	
Employer Address	City	State	Zip

By signing below, I verify that all information provided above is true and correct.

Signature of Patient or Guardian Date

PATIENT NAME: _____ TODAY'S DATE: _____

DIET HISTORY

Please list all foods and fluids consumed in the last 24 hours including food eaten after midnight the day before yesterday and indicate any items that were later purged. (Fluids means all water, milk, milkshakes, juice, soda, etc.)

FOODS	AMOUNTS	FLUIDS	AMOUNTS

EXERCISE HISTORY

Please list all exercise done in the last week, including length and intensity of each activity. If needed, please use space below to elaborate.

☐ I did not exercise over the last week.

	EXERCISE ACTIVITY	LENGTH	INTENSITY	TIME OF DAY
EXAMPLE:	Running	5 miles in 35 min.	Moderate	7 a.m.
SUNDAY:				
MONDAY:				
TUESDAY:				
WEDNESDAY:				
THURSDAY:				
FRIDAY:				
SATURDAY:				