Guam Seventh-day Adventist® Clinic

# Wellness Center Registration Form

Please complete BOTH sides of this form. One form per person. Participation is pending review of medical questionnaire (on back).

Name: ______________________________________________

Address: ______________________________________________

Tel (Home): ____________________ Tel (Mobile): ____________________

Tel (Work): ____________________ Email: ____________________

Date of Birth: ____________________ Physician: ____________________

Primary Insurance: ____________________ Secondary Insurance: ____________________

| Wellness Programs | Program Dates (See Wellness ads) | Actual Cost | Copay |
|---|---|---|---|
| **7-Day Shape Up** | | $350 | |
| **7-Day Detox + NEWSTART (Starts Mon)**<br>☐ I would like to opt out of NEWSTART program | | $350 (+$525) | |
| **7-Day Adv. Shape Up + NEWSTART (Starts Tue)**<br>☐ I would like to opt out of Adv. NEWSTART program | | $350 (+$525) | |
| **7-Day Adv. Detox/Adv. Shape Up + Adv. NEWSTART (Starts Fri)**<br>☐ I would like to opt out of Adv. NEWSTART program | | $350 (+$525) | |
| **NEWSTART** | | $525 | |
| **Advanced NEWSTART** | | $525 | |
| **DiaBeatIt:**<br>**Living Well with Diabetes** | | $1365.04 | |
| **Stop Smoking** | | $241.83 | |

I understand that it is my responsibility to inform the wellness staff about my medical condition.

My no show on pre-program appointment means I am canceling my enrollment in the program/s and my copay will be applied to processing fee, which is non-refundable.

**I understand that I am responsible for fees not covered by my insurance carrier(s). Refund may be requested for cancellation PRIOR to registration deadline (see wellness ads). Copay is non-transferable to the next program prior to completion of program.**

**If I do not complete the program I will be responsible for the entire cost of program, which will be billed to me.**

By providing my email address above, I understand that I will be sent updates, newsletters, educational material, notices about future programs, and other notifications via email or phone from the Guam Seventh-day Adventist Clinic.

Patient Signature ______________________________ Date ______________________

***Please complete health information on back of form.***

*Updated October 27, 2023*

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| **Check the box if you currently have or ever had any of the following conditions:** | **YES** | **If yes, please explain** | **List medications you are currently taking for the condition** |
|---|---|---|---|
| None | ☐ | ______ | ______ |
| Anaphylaxis or throat swelling | ☐ | ______ | ______ |
| Angina | ☐ | ______ | ______ |
| Anxiety of depression | ☐ | ______ | ______ |
| Arthritis, joint problems, gout | ☐ | ______ | ______ |
| Chronic fatigue syndrome | ☐ | ______ | ______ |
| Diabetes or gestational diabetes | ☐ | ______ | ______ |
| Gallstones | ☐ | ______ | ______ |
| Heart attack or stroke | ☐ | ______ | ______ |
| Heart palpitations, fluttering, thumping, Pounding or racing | ☐ | ______ | ______ |
| Heart murmur | ☐ | ______ | ______ |
| Hepatitis | ☐ | ______ | ______ |
| High blood pressure | ☐ | ______ | ______ |
| High cholesterol | ☐ | ______ | |
| Kidney stones | ☐ | ______ | ______ |
| Lightheaded, weakness, dizziness, fainting | ☐ | ______ | ______ |
| Migraine | ☐ | ______ | ______ |
| Thyroid disease | ☐ | ______ | ______ |
| | | | ______ |
| Blackouts | ☐ | ______ | |
| Cancer or on chemotherapy | ☐ | ______ | ______ |
| Food allergy | ☐ | ______ | ______ |
| Gastrointestinal disorders (Crohns, ulcer, etc.) | ☐ | ______ | ______ |
| Kidney failure, or on dialysis | ☐ | ______ | ______ |
| Lung or chest problems (asthma, COPD, TB, Pneumonia, bronchitis, require oxygen) | ☐ | ______ | ______ |
| | | | ______ |
| Surgery | ☐ | ______ | |
| Other (specify): | ☐ | ______ | ______ |
| | | | ______ |

☐ See previous enrollment form within 1 month

I attest the information provided on this form is current and accurate:

Patient initials: ______________ Date: ______________

Patient name: ______________ DOB: ______________

**WELLNESS CENTER**
**Staff Use Only**

☐ Pt Cleared
☐ Pt Not Cleared

______________
Staff Signature

Date: ______________