Medical Intake Summary

Submission ID: submission-1764116282

Patient Profile

PATIENT
John Smith

DOB
03/15/1985

GENDER
Male

PHONE
8135551234

EMAIL
john.smith@example.com

ADDRESS
456 Oak Street
Tampa, FL 33615

MEDICAL & MENTAL HEALTH HISTORY

Blood Pressure	130/85
Allergies	Penicillin - rash

ADDITIONAL MEDICAL INFORMATION

Medical History	Hypertension, controlled with medication
Current Medications	Lisinopril 10mg daily
Weight	220 lbs

ADDITIONAL RESPONSES

First Name	John
Last Name	Smith
Email	john.smith@example.com
Phone	813-555-1234
Date Of Birth	1985-03-15
Gender	male
Address	456 Oak Street
City	Tampa
State	FL
Zip Code	33615
Emergency Contact	Jane Smith - 813-555-5678
Insurance	Blue Cross Blue Shield
Policy Number	BCB123456789
Chief Complaint	Requesting weight loss medication - Semaglutide
Height	5ft 10in

ADDITIONAL RESPONSES (CONT.)

Heart Rate	72 bpm

Legal Disclosures & Consents

• Privacy Policy & HIPAA Compliance: I understand my health data is stored securely in accordance with HIPAA regulations and will be used solely for treatment coordination. I acknowledge that my protected health information (PHI) will be shared only with authorized healthcare providers and pharmacy partners involved in my care.

• Weight-Loss Treatment Consent: I authorize EONMEDS and its affiliated medical professionals to review my intake form, laboratory results, vital signs, and medical history to determine candidacy for GLP-1 receptor agonists and adjunct therapies. I understand that treatment recommendations are based on medical evaluation and may be modified or discontinued based on clinical response.

• Telehealth Services Agreement: I consent to receive healthcare services via telehealth technology and understand that these services are subject to the same standards of care as in-person visits. I acknowledge that technical issues may occasionally affect service delivery and that alternative arrangements will be made when necessary.

• Financial Responsibility & Cancellation Policy: I understand that cancellations or rescheduling within 24 hours of scheduled appointments may incur fees up to the full consultation cost. I acknowledge responsibility for all charges not covered by insurance and agree to the payment terms outlined in the financial agreement.

• Informed Consent & Risk Acknowledgment: I have been informed of the potential risks, benefits, and alternatives to GLP-1 therapy. I understand that individual results may vary and that no specific outcome is guaranteed. I agree to report any adverse effects immediately to my healthcare provider.

Digitally signed by
John Smith
11/25/2025, 7:18:02 PM
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