

Application

RETURN IMMEDIATELY!
FAX: (530)-422-7922

Session Date: ___ / ___ / ___ (mm/dd/yy)
 Name: _____
 Nickname:(foryourbadge) _____
 Home Phone: _____
 Mobile Phone: _____
 Email Address: _____
 Street Address: _____
 City: _____ State: ___ Zip: _____
 Social Security No.: _____
 Occupation: _____
 Height: _____ Weight: _____ Sex: Male Female
 Birth Date: ___ / ___ / ___ (mm/dd/yy) Age: _____
 Single Married Widowed Divorced Separated
 Spouse's name: _____
 My health conditions include:
 Asthma Arthritis
 High Blood Pressure Fibromyalgia/Lupus
 Diabetes I Excess Weight
 Diabetes II Oral Insulin
 Heart Disease Depression/Stress/Anxiety
 Type of Cancer: _____
 Type of Allergies: _____
 Any other disease, illness, or disorders? _____

List the foods you are allergic to, if any: _____

Do you use alcohol? _____ How often? _____
 Do you smoke? _____ How many cigarettes per day? _____
 I consider my present health:
 Excellent Good Average Poor Very Poor
 Do you have any other mobility or sight restrictions?

If you can walk without assistance, indicate how far:
 Less than 1/4 mile (about 1 city block)
 More than 1/4 mile, but less than 1 mile
 More than 1 mile at a time
 Can you walk: Indoors Only Outdoors-level Hills

How did you hear about the NEWSTART program?
 TV Radio Magazine Former Participant
 Other: _____

May we share your contact information with past or present NEWSTART guests? Yes No
 Are you a NS alumnus? No Yes. Year attended? _____
 If yes, your physician preference: _____

Do you have medical insurance? Yes No
 Is Medicare your primary: insurance? Yes No
 Does Medicare pay first? Yes No
 Do you have an HMO? Yes No
 Does your insurance company limit where you receive medical care? Yes No
 What is your Medicare No.? _____
 Do you have Part B coverage? Yes No
 Do you have a secondary insurance or Medicare supplementary insurance? _____
 Primary physician: _____
 Physician's phone: _____
 Who would you like us to contact in case of an emergency?
 Name: _____
 Relationship: _____
 Phone (daytime) _____ (eve) _____
 If your spouse is attending, do you prefer?
 King Twin Beds
 I plan to travel by: Car Train Bus Plane
 Special Request: _____

Please complete this application, including a deposit for one-half of the program fee for each guest, payable to Weimar Institute, by check, money order, or credit card. Please note that a \$500 portion of your deposit is non-refundable. Your medical fee may be paid to the NEWSTART Medical Clinic at the time of your first doctor appointment.

Amount enclosed \$ _____
 Deposit made by credit card:
 Visa MC AmEx Discover
 Card # _____ Exp. ___ / ___
 3-digit Credit Verification Code (CVC): _____

I HAVE READ THIS ENTIRE APPLICATION AND/OR HAD IT THOROUGHLY EXPLAINED TO ME. I AGREE THAT ALL OF THE INFORMATION I HAVE PROVIDED HERE IS TRUE AND CORRECT. I FURTHER UNDERSTAND THAT WEIMAR INSTITUTE DOES NOT PROMISE OR GUARANTEE ANY CURE FOR ANY AILMENT OR DISEASE. I AGREE TO PAY THE FULL PROGRAM AMOUNT.

Signature of NEWSTART Lifestyle guest _____ Date _____

For administrative use only: Rep: _____
 NSC CPK R _____ Prog. Fee \$ _____
 T F W _____ Med. Fee \$ _____