



**PATIENT REGISTRATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex (M/F) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone # (the best number to reach you at) \_\_\_\_\_ SS# \_\_\_\_\_

Single Married Divorced Widow Separated

Marital Status \_\_\_\_\_ Spouses Name \_\_\_\_\_

| <u>Insurance Information</u> |  |
|------------------------------|--|
| Name of Primary Insurance    | Subscribers Name / Date of Birth / SS# |
| Name of Secondary Insurance  | Subscribers Name / Date of Birth / SS# |

| <u>Medical Information</u>                                |
|---|
| Primary Care Physicians Name:                             |
| Phone:  |
| Address: (Please Provide as much information as you can.) |

Who referred you? \_\_\_\_\_

I authorize the release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the dietitian or supplier of services for myself or dependants. I understand I am responsible for any deductibles, co-insurance or amounts for services not covered by the insurance carrier and that all payment is required in full at time of service. In signing this form I am also authorizing the dietitian to counsel and treat me.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I have no objections to the dietitian discussing my nutritional care and treatment with the following persons:

\_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

What number is the best place a message? (Please provide the number.)

\_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell)