Patient Information Form

Patient Name: _____SSN _____ Gender: M/F

Birth date: ____/_____/_____ Marital Status: Single / Married / Other: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home #: (___)_____ Work: (___)_____ Cell: (___)_____

Email Address: _____

Referring Physician: _____ Phone: (___)_____

Primary Care Provider: _____ Phone: (___)_____

Emergency Contact: _____ Phone: (___)_____ Relation: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone #: (___)_____

If you have no insurance please specify

Subscriber Id #: _____ Group #: _____

Subscriber Name: _____ Date of Birth: ___/____/_____

Subscriber Employer: _____Relationship to the patient: _____

Secondary Insurance: _____ Group #: _____

Subscriber Name: _____ Date of Birth: ___/____/_____

Subscriber Employer: _____Relationship to the patient: _____

FINANCIAL AGREEMENT

The above information is true to the best of my knowledge. I understand billing my insurance is a courtesy provided to me from the nutritionist at no additional cost, and does not relieve my financial responsibility. I agree that the nutritionist may furnish the responsible insurance company and other authorized parties with the necessary information to process my claims in a timely manner. I also understand that I am responsible for any non-covered services, deductibles, co-pays or co-insurances that are no covered by my insurance company. IF AN INSURANCE CARD (S) IS NOT PROVIDED AT THE TIME OF SERVICE, YOU MAY BE BILLED PRIVATELY FOR ANY SERVICES RENDERED OR YOUR APPOINTMENT MAY BE RESCHEDULED.

Signature: _____ Date: _____/_____/_____