Personalized Nutrition For The Whole You

# SIMPLICITY NUTRITION

## REGISTRATION FORM

Full Name_____DX Code (office use only)_____

Please complete all areas of form and provide a copy of your insurance card(s)

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PATIENT INFORMATION

Patient Address_____ City_____

State____ Zip Code_____ Email _____

Home (___)_____ Work (___)_____ Cell (___)_____

Okay to leave a message at: HOME? Yes No WORK? Yes No CELL? Yes No

SS#_____ Date of Birth_____ Employer_____

Occupation _____ Name of Spouse/Partner_____

Emergency Contact _____ Phone (___)_____

PERSON RESPONSIBLE FOR PAYMENT (if not patient) _____

Responsible Party Billing Full Address _____

Relationship_____ Contact# (___)_____ SS#_____

PRIMARY INSURANCE

Primary Insurance_____

Claims Address_____ Phone (___)_____

Subscriber Name_____ Relationship to Patient_____

ID#_____ GROUP#_____

SECONDARY INSURANCE

Secondary Insurance_____

Claims Address_____ Phone (___)_____

Subscriber Name_____ Relationship to Patient_____

ID#_____ GROUP#_____

REFERRAL SOURCE/PRIMARY CARE PHYSICIAN

I was referred by_____ PCP/Phone#_____ (___)_____

I, _____ , have been given a handout explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions I have. I understand my rights and responsibilities as outlined in the above-mentioned handout. I am also responsible to pay for all missed appointments and late cancellations.

Patient and/or Guardian Signature_____ Date_____