Personalized Nutrition for the Whole You

SIMPLICITY NUTRITION

PATIENT REGISTRATION FORM

Patient's Full Name ______________________________________ **DX Code(s)** ____________________

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

PATIENT INFORMATION

Patient Address ____ City ______________________

State ______ Zip Code ___________ Email ____

Home (_____) _______________ Work (_____) _______________ Cell (_____) _______________

OK to leave a message: at HOME? YES NO at WORK? YES NO on CELL? YES NO

Employer __________________________ Occupation ___________________________________

Date of Birth _______________ Name of Spouse/Partner ___________________________________

Emergency Contact Name ________________________________ Phone (_____) _______________

PERSON RESPONSIBLE FOR PAYMENT (IF NOT THE 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 that I might have. I understand my rights and my 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 _____________

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