## Nutrition ExChange, LLC

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last name: | | | | | | | | | | | | | First | | | | | | | | | | |  | |  | | | | |  | | | | | | Birth date | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | /       / | | | | | | | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | Home phone no.: | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | (       ) | | | | | | | |
| City: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | ZIP Code: | | | | | | |
|  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please bring your insurance card and photo ID.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | Birth date: | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | |
|  | | | | /       / | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | (       ) | | | | | | | | |
| Is this person a patient here? | | | | Yes | | | | | | | No | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Occupation: | | Employer: | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | |
|  | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | (       ) | | | | | | | | |
| Is this patient covered by insurance? | | | | | | | Yes | | | | | | | | No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | | | |  | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | |  | | | | | | |  | | |
|  | | |  | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | |  | | | |  | | | | | |
| Subscriber’s name: | | | | |  | | | | | | | | | | | | | | |  | | | | | | Policy no.: | | | | | | | | | | Group no.: | | | | | | |  | |
|  | | | | |  | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | |  | | | | | | |  | |
| Patient’s relationship to subscriber: | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | Policy no.: | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | |
| Patient’s relationship to subscriber: | | | | | | | | |  | | | | | | | |  | | | | | |  | | |  | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | | Home phone no.: | | | | | | | | Work phone no.: | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | (       ) | | | | | | | | (       ) | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinician. I understand that I am financially responsible for any balance. I also authorize Nutrition ExChange or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | |  |
|  | *Patient/Guardian signature* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | *Date* | | | | | | | | | |  |