## Nutrition ExChange, LLC

# REGISTRATION FORM

|  |
| --- |
| (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* |  |