# CLIENT REGISTRATION FORM

Full Legal Name*:* ___________________________________________________Date_________________

Address: ________________________________________________________________________________

City: __________________________________________ State: ________ Zip: ______________________

What is your preferred method of contact: cell. home email

cell phone number ________________________

home phone number ________________________

email address________________________

Occupation: ____________________________________________ _Date of Birth___________________

Age today_______

How did you learn about me?______________________________________________________________

Insurance Plan Name __________________________________________________________________

*Please provide a copy of your insurance care. (The following information may be omitted if providing copy of insurance card)*

Number_______________________________________ Group Number____________________________

Subscriber _______________________________ (if not self, DOB): ________________________

Relationship to self____________________________

Do you have another plan? If YES, what is secondary

Insurance____________________________________

Amount of Copay. $ _______________ Do you have a physician referral with you? YES NO

Are you covered for nutrition visits? YES NO Not Sure

Have you confirmed coverage with your insurance provider? YES NO.

Have you met your yearly deductible for specialists? YES NO

**If you are denied coverage by insurance provider, you will be responsible for payment.**

For office use only - Diagnosis Code for Billing ________________________

Modified on 1/4/19