REGISTRATION FORM **PLEASE PRINT**

NAME:

____

> LAST FIRST MIDDLE INITIAL

STREET____

CITY___________________________ STATE________ ZIP CODE____________________________________

REFERRING DOCTOR /PCP____________________________ ALLERGIC TO_____________________________

HOME PHONE _______________________________ JOB PHONE____________________________________
BIRTH DATE____________________ SS # ________________ SEX______ M_______ F_____ HEIGHT________
WEIGHT_____ MARITAL STATUS MARRIED_________ SINGLE________ DIVORCED________
WIDOWED_______ EMPLOYER'S NAME, ADDRESS____

SPOUSE'S NAME____
SPOUSE'S EMPLOYER____
PHONE___________________________________DO YOU HAVE MEDICARE? YES________ NO_____________
MEDICARE#___________________________ IS IT YOUR PRIMARY? __________________________________
OR SECONDARY________________________

PRIMARY INSURANCE COMPANY____
POLICY #____________________________________ GROUP #_____________________________________
PATIENT RELATIONSHIP TO INSURED? SELF________ SPOUSE_______ CHILD_______ OTHER______ INSURED'S NAME, IF NOT THE SAME__________________________DOB_______________________________________
STREET____
CITY____ STATE_______________ ZIP CODE____________
SECONDARY INSURANCE COMPANY____
POLICY # ____ GROUP #_______________________________

PATIENT RELATIONSHIP TO INSURED? SELF_______ SPOUSE_______ CHILD_______ OTHER

INSURED'S NAME, IF NOT THE SAME_______________________DOB__________________________________
STREET____
CITY____ STATE_______________ ZIP CODE____________

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES OR its INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PROVIDER, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICAL CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. IF YOUR INSURANCE COMPANY FAILS TO PAY FOR SERVICES, YOU WILL BE RESPONSIBLE.FOR PAYMENT.
SIGNED____ **DATE**______________________________

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME____PHONE___________________

__________________________ RELATIONSHIP____

SECONDARY#____

ACKNOWLEDGMENT:

I, ____, acknowledge that I have been provided with a copy of _________________, Privacy Notice and have been given an opportunity to read and ask questions about the notice.

Date: ____

PATIENT'S SIGNATURE_____________________________

Do not write below this line (for Verification Admin to fill-out)

VERIFICATION OF BENEFITS

CLIENT: DOB: INS: _________________ INS. ID#: _______________

COVERED BENEFIT:

CPT CODE: _____________ DX:_________________ DX CODE(S):_______________

DEDUCTIBLE: ________ AMT:__________ MET:__________ REMAINING:___________

COPAY:

COVERAGE:

REFERRAL:

COVERED VISITS:

NUTRITION PREVENTIVE BENEFIT: _____ CPT CODE: _________ DX CODE:_________

COVERED VISITS:

PROVIDER REP:____________ TELCON REF#:_______________ DATE:_____________

NOTES/COMMENTS:

50 Jeanne Dr., Newburgh, NY 12550 | phone: 845-566-3506 | fax: 845-926-3347 | **mynutritionlink.com**