Araceli Vázquez, MS, RD, LD

NUTRITIONAL ASSESSMENT REGISTRATION FORM

Date:______________________________**Appt. time:**_______________________

Patient's information:

Name: (Last Name, First Name, Middle Initial)____

Address:____**City**:_____________________________

State_____________**ZipCode**_____________**phone** (include area code)____________________________

Email:____

May We leave messages by phone: Yes(   ) No ( ) **DOB**(MM/DD/YYYY)_______________________________

Age:__________**Sex:** Male ( ) Female ( )_____________**HEIGHT**:_________**WEIGHT**__________

Occupation:_________________________**Marital Status**_______ **Number of children**________________

How Can I help you today and what is the reason of your visit?: ___________________________________

____

Referring Physician's Name, Phone # and address____

____

Insurance Information: (copy of your medical insurance's card and photo ID required)

Patient relationship to insured: Self (   ) Spouse(   ) Child(   ) Other(   )

Insured's I.D.Number and Name____

Insured's Name (Last Name, First Name, Middle Initial)____

Insured's address:____**City**_____________________________

State_____**ZipCode**_____**phone** (include area code)_____________**Insured's Policy Group:**_________________

Insured's DOB(MM/DD/YYYY)_____________ **Sex:** Male ( ) Female ( ) **Employer's Name/Program Name and Address:**____

Emergency Contact Name and Phone Number:____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize direct payment of medical nutrition therapy benefits to Araceli Vazquez, MS, RD, LD for services rendered**; and** authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I certify that the above information given by me is correct. I understand that I am financially responsible for any balance not covered by my insurance. I understand that the above provided information may be used in any collection efforts of past due balances.

SIGNED____**Date**______________________________

Witness/Counselor____

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