Nutrition Advantage

Name: _____ Date: _____

DEMOGRAPHIC INFORMATION

TODAY'S DATE: _____

NAME LAST: _____ FIRST: _____ MI: _____

TITLE: ___MR ___MRS ___MISS ___DR ____OTHER GENER: ___M ___F

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER _____

ADDRESS Street/Apt: _____ City: _____ State _____ Zip: _____

PHONE Home: _____ Work: _____ EMAIL: _____

WHERE DO YOU PREFER WE LEAVE A MESSAGE? Home _____ Work _____

MARITAL STATUS: Single: _____ Married: _____ Divorced: _____ Seperated: _____ Widowed: _____

EDUCATION:(Highest grade completed or degree obtained)_____

SPECIAL CERTIFICATION _____

EMPLOYMENT STATUS: Full-Time:_____ Part-Time:_____ Retired:_____Unemployed:_____Disabled: _____

CURRENT EMPLOYER: _____ OCCUPATION: _____

CURRENT SCHOOL: _____ YEAR:_____ COURSE OF STUDY _____

IF PATIENT IS A DEPENDENT:
Residential Parent Name: _____

Non-Residential Parent Name: _____ Phone # _____

Address: _____

Email: _____

PERSON TO CONTACT IN EMERGENCY:
Name: _____

Home Phone: _____ Work Phone: _____

Address: _____

PRIMARY INSURANCE COVERAGE

Name of Primary Insurance Coverage: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Subscriber # _____ Insurance Group # _____

Customer Service Number: _____

Policy Holders Name: _____

Birthdate of Policy Holder: _____/_____/_____

Social Security Number of Policy Holder _____/_____/_____

Patient Relationship to Insured: _____ Self _____ Spouse _____ Dependent

Employer of Policy Holder _____

Responsibility for Payment

I understand and acknowledge the following terms and conditions for collection and payment of services provided.

I agree to complete necessary paperwork and to provide a copy of my insurance card if from a participating insurance plan.

I agree to notify the office at least 24 business hours before a scheduled appointment if i can not keep the appointment. (Emergencies Excluded) A $50 cancellation fee will be assessed for missed appointments without notification, at the discretion of the office.

FOR AETNA, ANTHEM, MEDICAL MUTUAL, & UNITED HEALTHCARE:
I authorize Nutrition Advantage, LLC to bill my health insurance plan for direct payment.

I agree to pay all copayments and deductibles required by my plan.

I agree to pay for services rendered that are not covered by my plan.

FOR ALL OTHER HEALTH INSURANCE PLANS:
I agree to pay for services at the time they are delivered.

Signature of Client/Parent Guardian: _____ Date: _____