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REGISTRATION FORM

DATE: _____/_____/_____

PATIENT INFORMATION:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip_____

E-mail: _____

Telephone: (home) _____ (Work) _____

Cell: _____

Sex: ___M ___F Date of Birth: _____/_____/_____

INSURANCE INFORMATION:

Insurance Co.: _____

ID#/Group#: _____ (Group): _____

Subscriber's Name: _____

Subscriber's DOB: _____/_____/_____

Relationship to Patient: _____

Is patient covered by additional insurance? ___Yes ___No

2nd Insurance Co.: _____

ID#/Group#: _____ (Group): _____

Subscriber's Name: _____

Subscriber's DOB: _____/_____/_____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of insurance company(ies) and assign directly to Nutrition in Motion all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Nutrition in Motion may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determine insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Guardian or Personal Representative:

_____

Please print name of Patient, Guardian or Personal Representative:

_____

Date:_____ Relationship to Patient: _____

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MEDICAL HISTORY

DATE: _____/_____/_____

PATIENT NAME: _____ PREFERRED NAME: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

REASON FOR APPOINTMENT/GOAL: _____

MEDICAL HISTORY

Check the following that you have been diagnosed with:

❍ High Blood Pressure ❍ Back Problems ❍ Headaches/Migraines ❍ Gastroparesis ❍ High Cholesterol

❍ Stomach Ulcers ❍ Diabetes: Type 1 or 2 ❍ Anxiety ❍ Anemia ❍ Depression

❍ Sleep Apnea ❍ Hypothyroidism ❍ Fibromyalgia ❍ Osteoporosis ❍ CKD stage _____

❍ PCOS ❍ Cancer type: _____

Any others not listed: _____

Food Allergies: _____ Food Intolerances: _____

Do you have a history of any eating disorder? (ie. Anorexia/Bulimia or Binge Eating) _____

Are you a vegetarian? ❍ Yes ❍ No

Please list any medications you are currently taking: _____

_____

_____

Please list any vitamins, herbs, or supplements you are currently taking: _____

_____

From past 5 – 10 years: _____ Lowest Weight _____ Highest Weight _____ Goal Weight

Are you currently exercising? ❍ Yes ❍ No If yes, how often, how long, and what types? _____

_____

Are you an emotional eater? ❍ Yes ❍ No If so, what triggers you to eat? _____

Have you had or are you considering Gastric Bypass surgery? ❍ Yes ❍ No

What is your current occupation? _____ How many hours/week do you work? _____

Do you smoke? ❍ Yes ❍ No How much and how often? _____

Do you drink? ❍ Yes ❍ No How much and how often? _____

Have you ever been seen by a dietitian before? ❍ Yes ❍ No If so, how long ago? _____

FAMILY MEDICAL HISTORY

Check those that apply, circle the direct family member:

❍ High Blood Pressure: Mother/Father ❍ High Cholesterol: Mother/Father

❍ Diabetes: Mother/Father ❍ Hyper/Hypothyroidism: Mother/Father

❍ Anemia: Mother/Father ❍ Obesity: Mother/Father

❍ Heart Disease: Mother/Father ❍ Osteoporosis: Mother/Father

❍ Nutrient Deficiency: Mother/Father ❍ Cancer: Mother/Father - Cancer type: _____

Any others not listed: _____

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A CLEAR PATH TO A HEALTHY LIFESTYLE

1505 Medical Center Drive
Wilmington, North Carolina 28401
910.239.3562

The following information is provided to avoid any misunderstandings of Nutrition in Motions policies and payment for professional services rendered.

- Nutrition in Motion has a 24 hour cancellation policy. If you do not call our office within 24 hours prior to your appointment, you may be responsible for the full amount of your appointment, even though you do not attend the session.
- As a courtesy to our patients that show up on time for their appointment, all patients that are late to their appointment may have to forfeit any time missed and may be responsible for the full amount of their appointment.
- Nutrition in Motion has a $35.00 return check fee on all returned checks. Note: Criminal procedures may take place if patient has a history of this matter, please make sure you have sufficient funds before signing check.
- Bills that are not paid within 90 days will be sent to collections.
- It is the responsibility of the patient to read all instructions on all supplements, read all ingredients in all supplements and contact their health care provider in reference to any questions regarding medication or health concerns prior to taking any supplements. It is also the responsibility of the patient to confirm any and all exercise and nutrition recommendations with their health care provider.
- Nutrition in Motion may report information about patients in the aggregate but does not release the patient's name without patient consent.
- I agree to have my health information shared with the referring physician
- Nutrition in Motion reserves the right to charge a reasonable fee for any extra copies and fax services.
- I also give permission for Nutrition in Motion to leave a voice mail if needed with the phone numbers I listed on my patient registration form.
- I understand Nutrition in Motion Notice for Privacy Practice. I understand that a copy is available at check in for patients to review. I understand that I may request a copy of the Notice of Privacy Practice at any time.
- I agree to be seen as a patient with Nutrition in Motion and agree to the above policies for Nutrition in Motion to the best of my knowledge, the information I share with Nutrition in Motion and its employees is correct.
- At the time of class/one-on-one visit, if there is a taste test offered or samples available, I participate per my own wishes and do not hold Nutrition in Motion liable for anything.

I HAVE READ AND I COMPLETELY UNDERSTAND ALL OF NUTRITION IN MOTION POLICIES AS STATED ABOVE.

Signature _____ Date _____/_____/_____