LSK NUTRITION
LORI KOLODIN, MPH, RD

REGISTRATION FORM - INSURANCE

Name:_____

Address: _____
street city state zip

Phone: _____
mobile home work

Birthdate: _____**Sex:** **M**☐ **F**☐ **Marital Status: M**☐ **S**☐ **D**☐ **W**☐

Profession: _____

Referring Physician: _____

Primary Insurance Company:_____

ID #_____**Group#**_____

Relationship to Insured: Self☐ **Spouse**☐ **Child**☐ **Other**☐

Insured Name & Birthdate: _____

Secondary Insurance Company: _____

ID#_____**Group#**_____

Relationship to Insured: Self ☐ **Spouse** ☐ **Child** ☐ **Other** ☐

Insured Name & Birthdate: _____

- *I authorize release of this form on all my insurance submissions.*
- *I authorize release of information to all my insurance carriers.*
- *I understand that I am responsible for the timely submission of a referral, if required.*
- *I authorize payment directly to Lori Kolodin, MPH, RD.*
- *I permit a copy of this authorization to be used in place of the original.*
- *I understand that I am responsible for my bill.*

Signature of patient Date

Name & signature of legally authorized person Date

LSK NUTRITION
LORI KOLODIN, MPH, RD

REGISTRATION FORM

MEDICAL & SOCIAL HISTORY

Full Name _____ **Birthdate:** _____

Height:_____ **Weight:**_____ **Email:** _____

Do you exercise? Please describe: _____

_____

- [ ] **Medical Conditions (please describe when applicable):**
- [ ] **Asthma**
- [ ] **Cancer**
- [ ] **Cardiovascular Disease**
- [ ] **Diabetes**
- [ ] **Drug Dependency**
- [ ] **Eating Disorder**
- [ ] **Food Allergies**
- [ ] **Gastrointestinal Disease**
- [ ] **Kidney Disease**
- [ ] **Headaches**
- [ ] **Heart Attack**
- [ ] **High Cholesterol**
- [ ] **Hypertension**
- [ ] **Menstrual Problems**
- [ ] **Mental Health Problems**
- [ ] **Obesity**
- [ ] **Osteoporosis**
- [ ] **Rheumatological Disease**
- [ ] **Other**

Please list your current medications:

_____

_____

Surgical history:_____

Physician's name_____

Please list your current supplements:

_____

_____

Alcohol consumption:

_____

Smoking history:

_____

Recreational drug use:

_____

Number of persons that live with you:

_____

Please best describe the following as it pertains to your current lifestyle:

Grocery shopping:_____

Cooking habits:_____

Meal preparation:_____

Dining out:_____

Family dinners:_____

What is your profession?_____

Are you employed? Yes☐ **No**☐ **If yes, please specify: full time**☐ **part time**☐

Please list all foods and beverages that you've eaten over the past 24 hours:

breakfast **lunch** **dinner** **snacks**

LSK NUTRITION
LORI KOLODIN, MPH, RD

REGISTRATION FORM

FINANCIAL POLICY

The purpose of my practice is to provide you with the best possible care. If you have health insurance, I am committed to helping you receive maximum allowable benefits. In order to achieve these benefits, I need you to understand my office policy.

It is the **patient's responsibility** to verify their health insurance benefits prior to their initial visit. It is your responsibility to understand how your insurance works and know what is required in terms of copays, referrals, authorizations, deductibles, and covered and non-covered services.

Payment will be collected at the end of each session for all copays and other non-covered services, when applicable. I accept credit cards, checks and cash.

Cancellations less than 24 hours prior to scheduled appointments will be charged a $50.00 fee; please be considerate.

****

Signature of patient date

Name & signature of legally authorized person date