LeSash Nutrition & Health, LLC
1864 Clove Rd. Suites D&E
Staten Island, NY 10304
Ph.: (347) 861-7666,   Fax: (866) 540-2266

PATIENT REGISTRATION FORM

Reminder: Co-payment is required at time of your visit

Please print clearly and complete all information in order for your claim to be processed quickly and efficiently.

PATIENT INFORMATION

Name: ____

Social Security No.: ____

Sex: ( ) Male ( ) Female   Date of Birth: _______/______/__________

Marital Status: ( ) single ( )Married ( ) Widowed ( ) Divorced

Address: ____

City, State and Zip: ____

Home phone: (___)________________Work #: (____)___________________ Cell #:(____)_____________

Employer: ____

Working Status: ( ) Full-time   ( ) Part-time   ( ) Unemployed   (   ) Retired

Are you a student? ( ) Yes   ( ) No

Parent/Guardian/Spouse's Name: ____

Primary Care Physician:_____________________________ Referred By: ____________________

INSURANCE AND RESPONSIBLE PARTY INFORMATION

Primary Insurance: ____

Policy !D #: ___________________________ Group #: _____________________________

Policy Holder's Name: ________________________ Relationship: _____________________

Policy Holder's Date of Birth: _____/_____/______ Social Security No.: ____________________

Policy Holder's Address: ____

Policy Holder's Phone No.: ____

Policy Holder's Employer: ____

Employer's Address: ____

Secondary Insurance: ____

Policy ID #: ___________________________ Group #: ____________________________

Policy Holder's Name: ________________________ Relationship: _____________________

Policy Holder's Date of Birth : _____/_____/______ Social Security No.: ____________________

Policy Holder's Address: ____

Policy Holder's Phone No.: ____

Policy Holder's Employer: ____

Employer's Address; ____

Emergency Contact:________________________ Phone #: __________________________

I hereby authorize that my insurance benefits be paid directly to Jennilyn Jackman Baptiste, RD,CDN / LeSash Nutrition & Health, LLC and acknowledge that I am financially responsible for any unpaid balance. Please remember that payment is your obligation regardless of insurance or other third party involvement.

__________________________ __________________________ __________

PRINT NAME ***SIGNATURE*** ***DATE***