LeSash
NUTRITION & HEALTH

1864 Clove Rd. Suite D & E Staten Island N.Y. 10304
Ph.: (347) 242-9804, Fax: (866)540-2266

PATIENT REGISTRATION FORM

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

Please print clearly and complete all in formation 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***