



# LeSash

NUTRITION & HEALTH

1864 Clove Rd. Suite D. Staten Island N.Y. 10304  
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## 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 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: \_\_\_\_\_

**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**