Eat Well and Beyond, LLP
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Patient Registration Form (please print)

Name:					Male Female
Date of Birth: / /	Age:	Marital Status (circle) S M D Sep W			
Home Address:					
City:				State:	Zip:
Telephone Number(s):	Home ( )	Wk. ( )		Cell ( )	
Occupation:					
Employed by:					
Business Address:					
City:				State:	Zip:

If child, person responsible for bill:					
Name:					
Relationship to patient: [ ] parent [ ] guardian [ ] other (describe)					
Home address if different from above:					
City:				State:	Zip:
Date of Birth: / /		Marital Status (circle) S M D Sep W			
Telephone Number(s):	Home ( )	Wk. ( )		Cell ( )	
Occupation:					
Employed by:					
Business Address:					
City:				State:	Zip:
Referred by (health care provider):					
City:				State:	Zip:

New Patient Information: Payment is expected at the time of your visit. Please advise us if there is a problem. Upon request you will be given a receipt (superbill) to submit to your insurance company for reimbursement. Insurance companies may or may not cover Medical Nutrition Therapy. Coverage may depend on the company, the policy, or the diagnosis. Please call your insurance company if you have questions about your coverage.

By signing this form, I acknowledge that I am responsible for this account and will make all payments at the time of visits, unless other arrangements for payments are agreed upon by Eat Well and Beyond, LLP.

Appointment cancellations must have a 24 hour notice.
Subject to a $25 Cancellation Fee if Less Than
24 Hours Notice.

Signature:	Date: / /20___
E-mail address:	

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