Lisa Stollman, MA, RD, CDE, CDN

Nutrition History Form

Name: ________________________________ Date: _______________________

Address: ___________________________ Town/Zip code: ___________________

Phone (H) __________________ (W) _________________ (C) ________________

Email: ________________________ Social security number: _________________

Occupation: ____________________________ Date of birth: __________________

Referral source: ________________________ Physician: ___________________

Address: ______________________________ Phone: ______________________

Insurance: ________________ Policy # _________________ Group # __________

Is there another plan? ________ If YES, please state which one: _______________

Who is responsible for bill/copay? _________ Amount of copay: _________________

Do you need a referral for this visit? YES NO
Do you have the referral with you? YES NO
Are you covered for nutrition visits? YES NO
Did you confirm coverage with your insurance provider? YES NO

You will be responsible for paying for today's visit if you did not confirm with your insurance provider.

Major nutrition concern: ____

Height: ___________ Weight: _____________Usual weight: _________________

Weight at HS graduation: _______ Lowest/highest weight in last 5 years: _____/______

Medications____

____

Supplements: ____

____

Do you have a history of intestinal problems such as bloating, excessive gas, constipation or diarrhea:____

Do you take laxatives: ____

Food allergies/intolerances: ____

Do you smoke cigarettes?: _____ If yes, for how many years?: ____ # per day: ______

Medical history: ____
____

Family medical history: ____
____

Past diet history: ____

Exercise (how often/type/duration): ____

I, the undersigned, certify that I or my dependent(s) have insurance coverage with the above named insurance provider. **I have contacted my insurance provider to confirm that I am covered for nutrition visits with Lisa Stollman, RD. Please be aware that your insurance company may still decline payment. If so you are responsible for payment.**

I assign directly to Lisa Stollman, RD all insurance benefits for services provided to me. I hereby authorize Lisa Stollman, RD to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance claims submitted for medical nutrition therapy.

If any fees are not covered by insurance, I understand that I am financially responsible for all accumulated charges. If I don't have a referral for this visit and require a referral, I will be responsible for paying for this visit today. All unpaid balances over 30 days will be sent to collection which will increase fees by 35%. I will also be fully responsible for payment of any appointments not cancelled within 24 hours. There is a $100.00 fee for appointments not cancelled within 24 hours.

______________________________ ____________________ ____________
Responsible party Relationship Date