Patient Registration

Patient Name_____ ☐ Male ☐ Female

Date of Birth_____ Age_____ Social Security #_____

Address_____ City_____ State_____ Zip_____

Phone, home:_____ cell:_____ work:_____

Email_____

Occupation_____ Employer_____

Alternate/ Emergency Contact_____

Relationship to Patient_____ Phone_____

Current Doctor_____ Phone_____

Referred by_____

Acceptance of Notice of Privacy Practices

I hereby acknowledge that Dandelion Nutrition has provided me with a copy of its Notice of Privacy Practices. I understand that I am entitled to receive updates upon request if Dandelion Nutrition amends or changes its Notice of Privacy Practices in a material way. The current HIPAA Privacy Notice is available at DandelionNutrition.com.

Patient's Signature_____ Date_____

Guardian's Signature_____ Date_____

Guardian's Name (printed)_____ Relationship_____

Marlene Maltby RDN, CSP, CD | Marlene@DandelionNutrition.com
ph 206-799-7010 | fax 206-866-0204 | DandelionNutrition.com

Financial Information and Agreements

Office Policies

- 24 hour notice is required for all canceled or rescheduled appointments. A $50 fee will be added to your account for missed appointments without appropriate notice.
- Payment is due at time of service, including copayments and out-of-pocket fees.
- Returned checks will incur a $40 fee.
- Outstanding balances without contributing payments for 90 days may be sent to collections. Any legal fee that Dandelion Nutrition incurs to secure past due balances will be added to your account.

Medical Insurance

Medical Insurance Company_____

Member ID#_____ Group#_____

Primary Card Holder's Name_____ & Date of Birth_____

Patient's Relationship to Primary Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other:

Insurance coverage for nutrition therapy varies greatly between plans.
Please verify your specific benefits prior to your appointment.

I authorize Dandelion Nutrition to apply for benefits on my behalf for services rendered. I certify that all information given is correct, and authorize the release of all information, including medical information, for this or related claims.

I understand Dandelion Nutrition may bill me for services rendered upon denial of my insurance company. I agree to be fully and personally responsible for payment.

I UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THE TERMS STATED.

Patient's Name (printed)_____

Patient's Signature_____ Date_____

Person financially responsible for payment (if not the patient):

Guarantor's Name (printed)_____ Relationship_____

Guarantor's Signature_____ Date_____

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Nutrition Intake Form

Patient Name _____ Date of Birth_____/_____/_____

Reason for today's visit: _____

_____

_____

What do you hope to achieve as a result of nutrition counseling? _____

_____

_____

Have you ever worked with a dietitian or nutritionist? ☐ Yes ☐ No

If yes, how was your experience? _____

_____

How would you describe your appetite? ☐ Poor ☐ Fair ☐ Good ☐ Great

Height_____ Weight_____ Usual Weight_____ Desired Weight_____

How satisfied are you with your weight and/or size of your body?

☐ Very Satisfied ☐ Mostly Satisfied ☐ Mostly Unsatisfied ☐ Very Unsatisfied

Any current or regular symptoms of:

☐ Nausea	☐ Diarrhea	☐ Gas/ bloating
☐ Vomiting	☐ Constipation	☐ Early fullness/ satiety
☐ Blood in vomit	☐ Blood in stools	☐ Extreme hunger/ thirst

☐ Other: _____

Personal Medical History (provide details as appropriate):

☐ ADD/ADHD	☐ Diabetes	☐ Osteoporosis
☐ Addiction	☐ Eating disorder	☐ PCOS
☐ Anxiety	☐ Feeding problems	☐ Reflux
☐ Autoimmune	☐ Genetic Abnormalities	☐ Reproductive/ fertility
☐ Breathing problems	☐ Growth problems	☐ Sleep problems
☐ Cancer	☐ Headaches/ Migraines	☐ Stroke
☐ Depression/ Mood	☐ Heart/ Cardiovascular	☐ Thyroid problems
☐ Digestive problems	☐ Kidney disease	☐ Weight problems

☐ Other: _____

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Dandelion Nutrition

Family Medical History (provide details as appropriate):

☐ Food Allergies ☐ Diabetes ☐ Heart Disease
☐ Cancer ☐ Eating Disorder ☐ Hypertension
☐ Depression/ Mood ☐ Headaches/ Migraines ☐ Weight Problems
☐ Other: _____

What medications do you take? _____

_____

_____

What vitamin/ mineral/ herbal supplements do you take? _____

_____

_____

How would you rate your stress level? (low) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (high)
How would you rate your energy level? (low) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (high)
How would you rate your activity level? (low) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (high)
What activities do you enjoy? _____

Are you currently employed: ☐ Yes ☐ No Occupation: _____
Do you smoke cigarettes? ☐ Yes ☐ No How much? _____
Do you drink alcohol? ☐ Yes ☐ No How much? _____
Do other substances? ☐ Yes ☐ No What? How much? _____

Please list any allergies you have (if any)? ☐ No known allergies
Foods: _____
Medications: _____
Environmental: _____

Do you follow a special diet or avoid certain foods (other than allergens)? ☐ Yes ☐ No
If yes, please describe: _____

_____

Is there any other information that we should be aware of? _____

_____

_____

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Release of Information

Patient's Name_____ Date of Birth_____

I authorize Dandelion Nutrition to contact and exchange records with the following healthcare providers regarding my care.

Name_____

Location_____

Phone_____ Fax_____ Email_____

Name_____

Location_____

Phone_____ Fax_____ Email_____

Name_____

Location_____

Phone_____ Fax_____ Email_____

Name_____

Location_____

Phone_____ Fax_____ Email_____

Patient's Signature_____ Date_____

Guardian's Signature_____ Date_____

Guardian's Name (printed)_____ Relationship_____

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