Kay S Beatty, MS, RDN
Healthy Weight Options, LLC

PO Box 79, Bergton, VA 22811
(c) 540-560-9232 (f) 844-387-5221
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New Patient Information Form

Today's date _____

Name _____

Address _____

Date of birth _____ **Age** _____ **Home phone #** _____

Work phone # _____ **Cell phone #** _____

Email address _____

Name and address of Primary Care Physician (PCP) _____

_____

Is this a referral? YES or NO If "yes," who referred you? _____

_____

May we exchange medical information with your Primary Care Physician? YES or NO

Name and Address of Your Medical Insurance Company _____

_____

_____

Name and address of person responsible for bill _____

Policy/ID Number _____ **Group#** _____

Policy Holder Name _____ **Policy Holder Birthday** _____

Relationship to Patient _____

May we exchange medical information with your insurance company for billing purposes? YES or NO

Your Occupation _____ **Your Employer** _____

Employer Address _____

Highest level of formal education _____

Gender: _____ **Height:** _____ **Weight:** _____ **Age:** _____

What issues brought you to seek nutrition counseling? _____

_____

What are your nutrition and health-related goals? _____

_____

Do you have any of the following health conditions? (circle all that apply)

Hypertension/high blood pressure	Diabetes	Prediabetes
Hypotension/low blood pressure	Arthritis	High Cholesterol
High Triglycerides	Constipation	Kidney Disease
Anorexia Nervosa or Bulimia	Celiac Disease	Gluten Sensitivity
Osteoporosis or Osteopenia	Liver Disease	Menopause
Hyperthyroidism	Hypothyroidism	Irritable Bowel Syndrome
Food Allergies (please list below)	Congestive Heart Failure	Autoimmune Disease (MS, LUPUS)

Please list any other medical conditions and elaborate on any of the conditions circled above.

_____

_____

Please list all prescriptions, over-the-counter medications and herbal supplements you take on a regular basis.

_____

_____

Are you currently on a special diet? YES or NO If "yes," what kind? _____

_____

At what activity level do you consider yourself? (circle one)

Sedentary Lightly Active Moderately Active Very Active Don't know

Do you engage in a structured exercise program? Yes/No **If "yes," what and how often?**

_____

Do you have any religious or cultural food restrictions? YES or NO If "yes," please describe

_____

Please list any food allergies or foods you cannot have for medical reasons _____

_____

Please use the space below to write anything else you'd like to share about your health or nutritional needs _____

Patient's Signature _____ **Name printed** _____

Representative's Signature, if applicable _____

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Payment Policy

Basic Policy:

Payment is due in full at time of service.

Insurance Patients:

All copays and deductibles are due at time of service. We may bill your insurance carrier for you, if we have a current contract with the carrier. Since your agreement is with your carrier is a private one, we do not routinely research why a carrier has not paid within 60 days of billing; our fees are due and payable in full, from you.

Non-Covered services:

If any services are not paid for by your insurance coverage, payment in full is expected at the time of service or immediately upon notice of insurance claim denial.

Patient's Signature _____

Patient's Name Printed _____

Date _____

Representative's Signature, if applicable _____

Representative's Name printed

_____