NUTRITION FORCE, LLC
REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Message can be left on phone: Yes No	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____ ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Other

Other family members seen here:

Reason for visit:

Person Responsible for Bill:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Nutrition Force, LLC to release information to my PCP if requested.

Privacy Consent

Nutrition Force, LLC requires your consent to use and disclose your protected health information to carry out treatment, payment, and health operations. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices. You have the right to review our Nice of Privacy Practices before signing this Consent. The terms of our Notice of Privacy Practices of Nutrition Force, LLC may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 231-527-9102. We will also post a copy of our current Notice of Privacy Practices in our office.

You have the right to revoke this consent in writing and the revocation will be effective except to the extent Nutrition Force, LLC has acted in reliance on your consent.

I have had an opportunity to discuss with the Registered Dietitian Nutritionist, the nature and purpose of medical nutrition therapy. I understand the results are not guaranteed. I give Nutrition Force, LLC permission to send a summary note to my physician or referring doctor of my consultation here.

By signing below, you herby consent to our use of your protected health information for treatment, payment, and health care operations and acknowledge receipt of a copy of this Consent if requested.

Patient/Guardian signature _Date_