Janai Meyer Nutrition and Lactation LLC

Registered Dietitian and Lactation Counselor

REGISTRATION FORM

Guardians Name	**Birth Date**
Today's date	

PATIENT INFORMATION

Patient's LAST NAME	**First name**	**Middle name**
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	
Birth date	Gender ❑ M ❑ F Marital status	
Mailing Address		SSN
Primary phone #	May we leave a message? ❑ Yes ❑No	Alternate phone #
E-mail address		TEXT PREFERRED ❑ Yes ❑No
Occupation	Employer	

Referred by	❑ Dr.	❑ Family	❑ Friend	❑ Online	❑ Other

*ETHNICITY ❑ Hispanic ❑ Non-Hispanic

*RACE: ❑ American Indian or Alaska Native ❑ Asian ❑ Black/African American ❑ White ❑Native Hawaiian or Other Pacific Islander

*Information is required by the government to meet meaningful use criteria.

INSURANCE INFORMATION

(Please provide your insurance card)

Person responsible for bill			
Mailing Address			Home phone #
Employer			
Employer address			
Is this patient covered by insurance?	**❑ Yes**	**❑ No**	

Please indicate primary insurance:

Policy Holder/Subscriber:			**Birth date**
Group #	**Policy #**	**SSN**	
Patient's relationship to policy holder	**❑ Self**	**❑ Spouse**	**❑ Child**	**❑ Other**
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Name of secondary insurance (if applicable):				
Policy Holder/Subscriber:	SSN	Birth Date	Policy #	
Patient's relationship to Policy Holder:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home phone #	Work phone #
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Janai Meyer, RDN LD IBCLC. I understand that I am financially responsible for any balance. I also authorize Janai Meyer, RDN LD IBCLC to release to my insurance company any medical or other information necessary to process my claims.

Patient/Guardian signature **Printed name** **Date**