

NEW PATIENT REGISTRATION



Nicole Cormier, RD, LDN

PATIENT INFORMATION

| | | | | | | | |
|--------|--|-------|----------------|---------------|---------|----------|---------|
| Name | | | | Date of Birth | | | |
| Street | | | Marital Status | Single | Married | Divorced | Widowed |
| City | | State | | ZIP | | Sex | M F |

CONTACT INFORMATION, for privacy purposes, please **circle** your preferred contact method

| | | | |
|---------------------|--|---------------|--|
| Telephone – day | | Cell phone | |
| Telephone - evening | | Email address | |

INSURANCE INFORMATION

| | | | | | | |
|--------------------------|--|--------|---------------|--------------------------|-------------------------|--|
| <u>Primary Insurance</u> | | | | Phone# | | |
| Insurance ID# | | Group# | | | Copay | |
| Insurance Address | | | | | | |
| Policy Holder, Name | | | Date of Birth | | Relationship to Patient | |
| Address | | | | Self Spouse Parent Other | | |

PRIMARY CARE PHYSICIAN INFORMATION

| | | | | | | | |
|--------------------|--|------|-------------------|--------|--|-----|--|
| Name | | | | Phone# | | | |
| Address | | City | | State | | ZIP | |
| Specialist/ Phone# | | | Therapist/ Phone# | | | | |

- I have been informed about and acknowledge reading the Notice of Privacy Practices for Nicole Cormier, RD
- I give Nicole Cormier, RD permission to speak with and disclose my protected health information with my physician.
- I understand that a 24 hr cancellation policy exists & that I will be charged for appointments that lack proper notification.

Signature: _____ **Date:** _____