LeSash
NUTRITION & HEALTH

Cell: 347-205-5166
Fax: 866-540-2266

PATIENT REGISTRATION FORM

Date of Service: ____/____/____ **Please fill in, initial and sign completely**

Patient's Name: ______________________________________ **Date of Birth:** ___/___/____ **Age:** _____ **Sex:** _______
Address:

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Phone: __________________________(H) **Mobile:** _____________________(c) **Email:** ____________________________________

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired Student: ☐ Yes ☐ No

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Method of Payment ____

Responsible Person's Name: __________________________________ Date of Birth: ___/___/___ Relationship : ________________
Referring Physician's Name: ________________________________ Primary Care Physician: __________________________________

Reason (s) For Visit:

Cancellation / No show Policy Appointment: If an appointment is not cancelled at least 24 hours in advance you will be charged a Twenty-five ($25.00) fee. **Scheduled Appointments:** If Client(s) is 15 minutes past their scheduled time, we will have to reschedule the appointment. **Account Balances:** Clients, we will require to pay account balances to zero prior to further services.
The information above has been reviewed and is correct. Client's / Authorized Person's Initials: ____________________

Authorization to Treat

I authorize Jennilyn Jackman Baptiste, RD, CDN / LeSash Nutrition & Health, LLC to provide necessary treatment including measurements, individualized meal plans, nutrition education, recommendations and any other as may in her professional judgement to be necessary.
Client's / Authorized Person's Signature: ____ Date: ______/_____/_____.

Authorization to Release Health Care Information

I request and authorize Jennilyn Jackman Baptiste, RD, CDN / LeSash Nutrition & Health, LLC to release healthcare information to the referring Physician and any other health professional I am referred to by Ms. Baptiste.
Client's / Authorized Person's Signature: ____Date: _____/_____/_____.