

New Patient Registration Form

PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work phone _____

Cell Phone _____ A message can be left on my _____ Phone _____

Email _____ Birth date _____ Gender Male Female

Occupation _____ Height _____ Weight _____

Name of custodian, guardian, or parent, if for a child _____

Person responsible for payment, if different from patient _____

Date of Birth _____ Phone if different than above _____

Address _____

City _____ State _____ Zip _____

MEDICAL INFORMATION

Name of Referring Physician or Primary Care Physician _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Please List all Medical Conditions _____

Please List all Prescription Medications _____

Please List all over the counter medicines (include vitamins, minerals, & herbal supplements

you are taking and the reason why you are taking it) _____

The following names are additional individuals that ELLAD Preventative Health, LLC is authorized to discuss any information regarding preventative health, medical nutritional therapy, and nutrition counseling services.
Names: _____

Our patient policies and HIPPA Privacy Notice & Agreement can be found at the receptionist desk.

I have read the patient policies (including missed and late appointment policy) and read the HIPPA Privacy Notice and Agreement to its terms to release information for treatment and services rendered.

Print your name _____

Signature _____ Date _____