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NEW CLIENT FORM

Patient Name: First Middle Last			**Home Phone**		
Home Address	**City**		**State**	**ZIP**	
Employer	**Address**		**Work Phone**	**Cell Phone**	
Occupation	**Social Security No.**	**Marital Status S M D W**	**Date of Birth**	**Age**	**Sex M ____ F ____**
Financially Responsible Person Patient Spouse Parent Other	**Name (if different from Patient)**		**Home Phone**	**Work Phone**	
Financially Responsible Person's Address (If Different From Patient)					
Spouse's Name					
Spouse's Employer			**Work Phone**		
Allergies					
In Case Of Emergency, Contact:			**Phone**		
Address					
Referred By	**E-mail address, if you would like to receive future correspondence via email.**				

Medicare	**Other Insurance**
I.D No.:_____ **Effective Date**_____	**Ins Co Name**_____ **Address**_____ **City, State, ZIP**_____ **I.D. No:**_____ **Group**_____ **Policy Holder's Name**_____
Medi-Cal	
I.D. No:_____	

WE REQUEST PAYMENT AT THE TIME OF SERVICE FOR ALL SERVICES RENDERED.
PLEASE READ AND SIGN BELOW.

I consent to the evaluation and treatment by LeeAnn Smith Weintraub, MPH, RD.
I understand and agree that I am financially responsible for all charges whether or not covered by insurance.

I hereby authorize LeeAnn Smith Weintraub, MPH, RD to release any necessary information, including medical information for this or any related claim, to my insurance carrier (or, in the case of Medicare Part B benefits to the Social Security Administration and the Health Care Financing Administration) or, in the case of workers compensation, to my employer in order to settle medical claims on my behalf.

In the event that LeeAnn Smith Weintraub, MPH, RD submits a claim, I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to the provider who rendered services. I permit a copy of this authorization to be used in place of the original.
This authorization may be revoked either by me or by the above named carrier at any time in writing.

Signature_____ Date_____