HARMONY WITH FOOD

Nutritionally Sound, LLC

Client's Name: _____ Date of Birth: _____

How did you year about us? _____

Client's Concern: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Client's email (optional): _____
(We will add you to our Harmony With Food/Nutritionally Sound newsletter if provided.)

Name of Primary Care Physician: _____

Physician's Phone: _____

Physician's Address: _____

Insurance: _____ (copy of card)

Are you the primary insurance holder? [ ] Yes / [ ] No

If no, list the name and date of birth of primary insurance holder:

Insured's Name: _____ Date of Birth: _____

List any Medications, Vitamins/Herbal Supplements you are currently taking:

_____

_____

_____

Please be advised that you (the Client) are responsible for any balance, copayment or deductible that your insurance states you owe. Also, if for any reason you need to cancel a scheduled appointment with less than 48-hour notice, you will be charged a missed appointment fee.

Signature: _____ Date: _____