Nutrition Therapy Consultants, Inc.

3615 Harding Avenue, Suite 510, Honolulu, HI 96816

Patient Registration Record

PATIENT INFORMATION (Please print clearly)			
Last Name		*First Name, M.I.*	
SSN	*DOB/Age*	*Sex*	*Marital Status*
Home Address		*Home Phone*	*Cellular/Pager*
City, State, ZIP		*Work Phone*	*Email*
Employment/School-Grad		*Ethnicity*	
Primary Care Physician		*Referred by*	

PERSON RESPONSIBLE FOR BILL		
Last Name	*First Name, M.I.*	
Mailing Address	*Home Phone*	*Cellular/Pager*
City, State, ZIP	*Work Phone*	*Email*

MEDICAL INSURANCE INFORMATION				
Primary Plan			*Member #*	*Group #*
Subscriber Information (if other than patient) *Last Name*			*First Name, M.I.*	
SSN	*DOB*	*Sex*	*Employer*	
Effective date			*To*	

IF PATIENT IS A MINOR OR AGE 18 & UNDER			
PRIMARY CONTACT *Last Name*		*First Name, M.I.*	
Home Address		*Home Phone*	*Cellular/Pager*
City, State, ZIP		*Work Phone*	*Email*
Relationship to Patient			
MOTHER *Last Name*	*First Name, M.I,*	*FATHER* *Last Name*	*First Name, M.I.*
Home Address		*Home Address*	
City, State, ZIP		*City, State, ZIP*	
Home Phone	*Cellular/Pager*	*Home Phone*	*Cellular/Pager*
Work Phone	*Email*	*Work Phone*	*Email*

Nutrition Therapy Consultants Inc.

Consent to Obtain and/or Release Information

Patient ______________________________ Birthdate_____________
Former Name (if any) ____

I authorize the exchange of information as noted below between Nutrition Therapy Consultants, Inc. and:

Name of Physician ______________________________ Phone ______________

Address _________________ City___________ State______ Zip Code_______

Name of Psychotherapist ______________________________ Phone ______________

Address _________________ City___________ State______ Zip Code________

For the purpose of:
(Check all that apply)

- ___Coordination of services
- ___Contact with referral source
- ___Continuity of care
- ___Litigation
- ___Treatment planning
- ___Other: ______________________

TYPE OF INFORMATION

Nutrition Therapy Consultants **WILL RELEASE**: (Check all that apply)	Nutrition Therapy Consultants **WILL OBTAIN**: (Check all that apply)
___Verbal and/or written communications ___Summaries only ___Laboratory Report(s) ___Consultation Report(s) ___Nutritional history and assessment Date Materials Sent:	___Verbal and/or written communication ___Completed Health Record ___Summaries only ___Laboratory Report(s) ___Consultation Report(s) ___Other:________________

PATIENT AUTHORIZATION

I hereby release Nutrition Therapy Consultants Inc. from all liability and claims of any nature whatsoever pertaining to disclosure of information or any professional opinions, findings, or recommendations as contained in clinical records. Records released under this consent are not to be considered part of the records of the facility receiving this information.

This authorization will expire one year from date of signature unless otherwise designated here:______________

Patient/Legally Responsible Party ___________________________ Date______________

Relationship to patient ___________________________ Date______________

Witness ___________________________ Date______________

Therapist ___________________________ Date______________