Dr. Gloria Bent, MS, RDN, CDN
Nutrition History Form

Name: _____ Date: _____

Address: _____ Town/Zip code: _____

Phone (H) _____ (W) _____ (C) _____

Email: _____

Occupation: _____ Date of birth:

_____ Referral source:

_____

Physician: _____

Address: _____ Phone: _____

Insurance: _____

Policy # _____ Group # _____ Is there

another plan? _____ If YES, please state which one: _____

***Please note: Our practice does not accept Medicaid plans at this time. All Medicaid plans will be self-pay for nutrition visits.

Who is responsible for bill/copay? _____ Amount of copay: _____

Would you like to receive **BOW! WOW!** newsletter: (please check) _ Yes _No

Do you need a referral for this visit? YES NO
Do you have the referral with you? YES NO
Are you covered for nutrition visits? YES NO
Have you met your yearly deductible for Specialists? YES NO

You will be responsible for paying for today's visit.

Major nutrition concern(s):

_____

Height: _____ Weight: _____ Usual weight: _____ Weight at

HS graduation: _____ Lowest/highest in last 5 years: _____/_____

Medications_____

_____

_ Supplements:

_____

_____

Do you have a history of intestinal problems such as bloating, excessive gas, constipation or diarrhea:

_____

Do you take laxatives: _____

Food allergies/intolerances: _____

Do you smoke cigarettes? _____ If yes, how many years? ____# per day: _____

Medical history (illnesses, surgeries): _____

_____

Family medical history: _____

_____

Past diet history: _____

Exercise (how often/type/duration): _____

Would you like information about our fitness program__YES __NO

Would you like a personal fitness coach __YES __NO

Eating Habits

Do you have times during which you eat uncontrollably? Please circle No Yes. If Yes, please explain: _____

Have you ever been diagnosed with an eating disorder? No Yes Do you skip meals? No

Yes If Yes, why? _____

Do you know how to cook? No Yes

Who does the cooking at home? _____

Who does the grocery shopping?_____

Eating Behaviors

	No	Yes		No	Yes
Do you eat standing up?			Do you eat fast?		
Do you eat in the car?			Do you eat when bored?		
Do you eat while watching TV?			Do you eat when stressed?		
Do you eat while reading or on the computer?			Do you eat when you are anxious?		
Do you prefer eating alone?			Do you eat when you are lonely?		
Do you eat with others?			Do you eat when you are not hungry?		
Do you read Nutrition Facts labels?			If yes, what do you look at on the label?		
What are your favorite foods?					
What foods do you avoid and why?					

Office Policy

We look forward to helping you achieve your health and nutrition goals. Making positive changes in your lifestyle is the cornerstone to good health. Here are my office policies which will help familiarize you with my practice.

Consultations

The initial visit is 45 to 60 minutes. Follow-up visits are 30 to 60 minutes. Office visits must end on time, so please be on time.

Please email a three-day food record for your visit. If you have any recent lab work, send that as well.

Referrals

If you need a referral from your physician, please email it before your initial visit.

Cancellations

If you need to cancel your visit, please do so **at least 48 hours** before the visit. Otherwise, you will be charged $150.00 for the visit.

Signature: _____ Date:_____

Credit Card Information

To ensure that we are paid for visits not canceled **at least 48 hours** in advance of the scheduled visit. **We require a credit card on file**. **We cannot reserve an appointment unless we have a credit card on file at least 72 hours before the scheduled appointment**. This information will not be shared with anyone. We will have to reschedule if we don't have a credit card on file.

Name on Credit Card: _____

Type of credit card: VISA Mastercard AmEx Debit HAS Credit Card#

_____ Exp. Date: _____ CVV_____ Billing zip

code: _____

Payments

I will also be fully responsible for payment of any appointments not canceled at least 48 hours in advance of my scheduled visit.

I have read the above financial obligation clause.

_____ _____ _____ Responsible

party Relationship Date

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

PATIENT: DATE OF BIRTH:

I understand that under the Health Insurance Portability Accountability Act of 1998, I have certain rights to privacy regarding my protected health information (PHI). I have received, read and understand the Notice of Privacy Practice. The practice reserves the right to change their terms of its Notice of Privacy Practice. I understand the practice will provide current Notice of Privacy Practice on request.

Signature: _____ Date: _____

Relationship to patient: _____Self _____Parent _____ Guardian

Permission to Release Health Information

I grant the right to Dr. Gloria Bent, RDN, CDN to release and/or obtain health information about _____ (patient's name) to my third party payers and the following healthcare providers or persons:

_____

_____

Signature of Person completing this form: _____

Relationship to patient: _____

Print name: _____ Date: _____

Please email this form to , at your earliest Bentonwellnesdrg@gmail.com convenience. We must have the completed history form before the nutrition consultation visit.