1324 Common St., Suite 307 | New Braunfels | Texas | 78130 | T: 830-468-5917 | F: 866-382-8390

New Patient Information

Personal Information

First Name: ________________ M.I.:___ Last Name: ______________________ Email: ___________________________

Address:_____________________________________ City: _____________________ State:________ Zip:__________

Home Phone: ____________________ Mobile Phone: ___________________ Work Phone:______________________

Employer: ____ Occupation: ___________________________________

Address:_____________________________________ City: _____________________ State:________ Zip:__________

Date of Birth:_____________________ Age:______________ Marital Status: ❑ Single ❑ Married

Physician Information

Primary Care Physician:_______________________________________ Phone: _______________________________

Address:_____________________________________ City: _____________________ State:________ Zip:__________

Referring Physician:____ Phone: _______________________________

Address:_____________________________________ City: _____________________ State:________ Zip:__________

Insurance Information

Primary Insurance Provider: ____ Date Effective: ________________

I.D.#: _______________________________________ Group #:____

Subscriber Name: ____ Date of Birth: _____________________

Relationship: ____ Phone Number: __________________________

Secondary Insurance Provider: _________________________________ Date Effective: ___________________________

(continued on next page)

Insurance Information

I.D.#: ______________________ Group #: ______________________

Subscriber Name: ______________________ Date of Birth: ______________________

Relationship: ______________________ Phone Number: ______________________

Preferred Contact Number

❑ Home: ______________ ❑ Work: ______________ ❑ Mobile: ______________

If mobile is preferred, are text messages okay? ❑ Yes ❑ No

Health History

Please List Your Health Concerns	Duration of Problem(s)

Have you ever worked with a dietitian/nutritionist? ❑ Yes ❑ No If yes, who? ______________ When? ______________

What was the date of your last physical? ______________________

Previously Diagnosed Conditions

❑ Anorexia/Bulimia	❑ Depression	❑ High Cholesterol	❑ PCOS
❑ Binge Eating	❑ Diabetes	❑ Inflammatory Bowel Disease	❑ Sleep Apnea
❑ Cancer	❑ Eczema/Skin Diagnosis	❑ Irritable Bowel Syndrome	❑ Thyroid Problems
❑ Cardiovascular Disease	❑ Food Allergies	❑ Kidney Disease	❑ Ulcerative Colitis
❑ Celiac Disease	❑ Gastroesophageal Reflux (GERD)	❑ Lactose Intolerance	❑ Other:
❑ Crohn's Disease	❑ High Blood Pressure	❑ Migraine Headaches	

Surgeries

Please List All Surgeries You Have Had	Date of Surgery

Medications *(prescribed and over the counter)*

Medication	Dosage	Times Per Day	Start Date

Vitamins and Supplements

Name	Dosage	Times Per Day	Start Date

Family Medical History

Health Problems	Relationship

Nutrition Assessment

Please explain your goals for nutrition counseling. Why have you sought help from a dietitian? ____________________

____

____

____

____

Current Height: ______ Current Weight: ______ Do you consider yourself to be: ❑ Overweight ❑ Underweight ❑ Just Right

Have you had any unintentional weight loss in the past six (6) months? ❑ Yes ❑ No If yes, please explain: ____________

____

Do you currently follow a special diet? ❑ Yes ❑ No If yes, please explain: ____________________

____

Appetite: ❑ Good ❑ Fair ❑ Poor Please explain: ____________________

____

Do you have any skin conditions? ❑ Intact ❑ Open Sores ❑ Ulcers If any, please explain: ____________

____

Do you have any difficulty swallowing? ❑ Yes ❑ No If yes, please explain: ____________________

____

Do you exercise? ❑ Yes ❑ No If yes, please describe the activity and how often: ____________

____

Food & Eating Habits Questionnaire

What are your favorite foods? ____________________

____

____

____

(continued on next page)

What are your *LEAST* favorite foods? ______________________________

____

____

Do you have any food allergies or intolerances? ❑ Yes ❑ No If yes, please explain: ______________________________

____

What meals do you typically eat every day? ❑ Breakfast ❑ AM Snack ❑ Lunch ❑ PM Snack ❑ Dinner ❑ Bedtime Snack

How many times per week do you eat out? ________ Breakfast ________ Lunch ________ Dinner ________ Other

Who cooks meals at home? ______________________ Who does the grocery shopping? ______________________

How often do you eat or drink the following...

Type of Food	Number of Times	Per Day or Week?
Red meat, sausage, bacon, cheese		
Fish		
Dairy		
Fruits		
Vegetables		
Grains (cereal, oatmeal, rice, pasta, bread, tortillas)		
Sweets		
Alcohol (wine, beer, liquor)		
Sugar sweetened drinks (soda, sports/energy drinks		

Food and Drink Tracker – Please record what you ate and drank yesterday, including amounts

	Time	Foods Eaten	Location
Breakfast			
Lunch			
Dinner			
Snacks			

Privacy Consent

Dionne Garner Nutrition LLC requires your consent to use and disclose your protected health information to carry out treatment, payment and healthcare operations. A complete description of such uses and disclosures is contained in our Notice of Privacy Practices, which is attached hereto. You have the right to review our Notice of Privacy Practices before signing this Consent. The terms of our Notice of Privacy Practices may change from time to time. You may obtain a copy of our revised Notice of Privacy Practices by contacting us at 830-468-5917. We will also post a copy of our current Notice of Privacy Practices in our office. You have the right to revoke this consent in writing and the revocation will be effective except to the extent Dionne Garner Nutrition LLC has acted in reliance on your consent.

I understand that proper nutrition can be an important complement, but not a substitute for medical care. I understand that desired results are not guaranteed. I give Dionne Garner Nutrition LLC permission to send a summary of our visits to my physician or referring doctor.

By signing below, you hereby consent to our use of your protected health information for treatment, payment and health care operations and acknowledge receipt of a copy of this Consent if requested.

Printed Name: ______________________________ Date: ______________________

Signature: ____

Payment and Appointment Policy

Payment is to be collected at the time of service in the form of cash, check or credit card.

There is a charge of $50 for any returned checks. All payments for returned checks, as well as further payments, will be due in cash or money order only.

I understand that any outstanding balance must be paid before the dietitian will see me.

We will file your insurance only if Dionne Garner Nutrition LLC is a provider under your insurance plan. You hereby authorize the release of all information, including medical information, for this or related claims. It is your responsibility to provide the necessary insurance information to do so, including authorizations and referrals. If this information is not provided prior to your visit, you will be required to make payment. If Dionne Garner Nutrition LLC is not a provider under your insurance plan, we will not file your insurance, but we will provide you with a superbill so that you may do so. ***Payment for services is due at the time of the visit.*** Your insurance is a contract between you and your insurance carrier and does not guarantee payment for nutrition services. We cannot become involved in disputes regarding claims, deductibles, co-payments, non-covered charges, or other denials of payment. We are required to collect any patient responsibility, as this is part of our HMO/PPO contract.

We are committed to being on time with appointments to prevent clients from waiting. ***Please call us immediately if you are running late for an appointment***. If you are more than 10 minutes late for your appointment, Dionne Garner Nutrition LLC reserves the right to charge the full consultation fee and your consultation time may be rescheduled.

Please provide 24 hours notice when canceling or rescheduling an appointment. If you fail to provide us with advance notice of a cancellation, our staff is unproductive during that reserved time. This will ultimately impact the kind and cost of the service we provide. Appointments that are missed (no-show), canceled or rescheduled with less than 24 hours advance notice will be charged $50. This policy applies to all clients regardless of insurance coverage.

I have read and agree to the Payment and Appointment Policy as written above.

Printed Name: ______________________________ Date: ________________________

Signature: ____