MARILYN TUCKER, MS, RD, CDE
Registered Dietitian

Westchester Office:
140 Lockwood Avenue
New Rochelle, NY 10801
914-632-1896

New York Office:
19 West 34th Street
New York, NY 10016
212-316-6476

PATIENT INFORMATION FORM

PLEASE PRINT

Patient's Name: ____
Last First Middle Initial M/F

Address: ____ Apt #: ________

City: ______________ State: ________ Zip: ________ DOB ________ Cell ______________

Daytime Phone: ______________________ Evening Phone: ______________________

INSURANCE INFORMATION

Primary Insurance Company: ______________________ ID#: ______________________

Name of Subscriber: ______________________ DOB: ______________________

Relationship to patient: Self Spouse Dependent Other

Name of Employer: ____

Address:
____

Name of referring physician: ____

Address: ____ Phone: ____________

Secondary Insurance Company: ______________________ ID#: ______________________

Name of Subscriber: ______________________ DOB: ______________________

Relationship to patient: Self Spouse Dependent Other

Name of Employer: ____

Address:
____

MARILYN TUCKER, MS, RD
Certified Nutritionist

PATIENT INFORMATION FORM

DATE________ NAME________________________ AGE______ REFERRED BY________________

List any vitamins, minerals, supplements you are presently taking:____________________

____

If hospitalized for **MORE THAN 24 HOURS** in the **PAST FIVE YEARS** please describe:________

____

Please list any **medications** you are presently taking:________________________________

____

List any foods you do not eat for **ANY REASON**________________________________

Describe any exercise you do 3 times a week for **AT LEAST 15 MINUTES.**

____

Describe your intake of salt: Salt shaker salty seasonings snacks other________________

____

How many lunches **A WEEK** are eaten in a restaurant______take-out______homemade_______

How many dinners **A WEEK** are eaten in a restaurant______take-out______homemade_______

Please indicate the number of cups you drink daily:

Regular Coffee________Regular Tea________Diet Cola______Regular Cola________

How many packs of cigarettes/cigars do you smoke? Day________Week________Month____

How many alcoholic drinks daily?________________________Weekly________________

Please describe why you wish to see a Nutritionist:

____

Please indicate what you usually eat during the day for Breakfast-Lunch-Dinner-Snacks

BREAKFAST	LUNCH	DINNER	SNACKS

MARILYN TUCKER, MS, RD, CDE
Registered Dietitian

Westchester Office:
140 Lockwood Avenue
Suite 107
New Rochelle, NY 10801
914-632-1896

New York Office:
19 West 34th Street
Penthouse
New York, NY 10016
212-951-7335

____
(Date)

PRIVACY WAIVER

I ____________________________ give permission for the following individual(s) to discuss all information relating to my medical condition(s) with my nutritionist, Marilyn Tucker-Viselli, MS, RD, CDN.

__________________ (Print Name)	__________________ (Relationship To Patient)
__________________ (Print Name)	__________________ (Relationship To Patient)
__________________ (Print Name)	__________________ (Relationship To Patient)
__________________ (Print Name)	__________________ (Relationship To Patient)

____
(Signature)

MARILYN TUCKER, MS, RD, CDE
Registered Dietitian

Westchester Office:
140 Lockwood Avenue
Suite 107
New Rochelle, NY 10801
914-632-1896

New York Office:
19 West 34th Street
Penthouse
New York, NY 10016
212-951-7335

MEDICAL RELEASE FORM

I give my permission that all pertinent medical records be sent to:

Marilyn Tucker-Viselli MS, RD CDE
Dietitian
140 Lockwood Avenue
Suite 107
New Rochelle, NY 10801

Tel: 914-632-1896
Fax: 914-632-4284

Thank you.

Print Name ______________________________

Signature ______________________________

Date ______________________________

MARILYN TUCKER, MS, RD, CDE

Registered Dietitian

Westchester Office:
140 Lockwood Avenue
New Rochelle, NY 10801
914-632-1896

New York Office:
19 West 34th Street
New York, NY 10016
212-316-6476

INSURANCE LIABILITY AND ASSIGNMENT

I, the undersigned certify that I or my dependent(s) have insurance coverage with

________________________________ and assign all insurance benefits directly to

Marilyn Tucker-Viselli.

This office will make every attempt to obtain payment from the insurance company for your nutrition office visit(s). However, in the event that your insurance company refuses to pay for nutrition consultations(s), I agree to be responsible for the direct payment of these fees to the nutritionist, Marilyn Tucker-Viselli.

I hereby authorize the nutritionist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Print Name

____
Signature

____
Date

________________________________ ____________________
Relationship Date

MARILYN TUCKER, MS, RD, CDE
Registered Dietitian

Westchester Office:
140 Lockwood Avenue
Suite 107
New Rochelle, NY 10801
914-632-1896

New York Office:
19 West 34th Street
Penthouse
New York, NY 10016
212-951-7335

MISSED APPOINTMENT POLICY

We kindly ask that you please cancel your nutrition appointments

NO LATER THAN 4:00 PM THE DAY BEFORE the scheduled appointment

time. Otherwise, we must charge a missed appointment fee of $85.00.

By signing this page, I agree to abide by this policy.

PRINT NAME ______________________________

SIGNATURE ______________________________

DATE ______________________________

NOTE: PLEASE KEEP ONE COPY FOR YOUR RECORDS.

MARILYN TUCKER, MS, RD, CDE
Registered Dietitian

Westchester Office:
140 Lockwood Avenue
Suite 107
New Rochelle, NY 10801
914-632-1896

New York Office:
19 West 34th Street
Penthouse
New York, NY 10016
212-951-7335

MISSED APPOINTMENT POLICY

We kindly ask that you please cancel your nutrition appointments **NO LATER THAN 4:00 PM THE DAY BEFORE** the scheduled appointment time. Otherwise, we must charge a missed appointment fee of $85.00.

By signing this page, I agree to abide by this policy.

PRINT NAME ______________________________

SIGNATURE ______________________________

DATE ______________________________

NOTE: PLEASE KEEP ONE COPY FOR YOUR RECORDS.