New Patient Paperwork

Name: ______________________________ SSN: ______________________

Contact Information

Mailing Address:____

____

Home Phone: _________________________ Cell Phone: ______________________

Email: ______________________________ Preferred Contact: Home Cell Email

Who referred you to ENW or how did you hear about us? _______________________

Friend/Family Website Insurance Social Media Physician

Insurance Information

Primary (if other than self): ____

Insurance Carrier:______________________________ Policy ID# _________________

Group #:____________________ Employer:__________________________________

General Information

Referral: YES NO Reason for Referral: ___________________________________

Primary Doctor: _________________ Physician Office Name:___________________

Physician Address/City: __________________ Contact Number: _________________

Ethnicity: _____________________ Occupation: ____________________________

Gender: Male Female Age: ___________ Birthday: _______________________

What are your most frequent symptoms/concerns? ___________________________________

____

Do you currently smoke? ______ Do you drink alcohol? ______ If yes, how much? _______

Do you exercise? _____ If yes, what kind and how often/long: _________________________

Do you have any food intolerances/allergies? ____

Last Menstrual Cycle: ________ Do you take any hormones/birth control? ______________

Current & Ongoing Eating & Health Concerns:

Concern	Severity/Frequency:	Previous Treatments	Current Status

Current & Recent Medications & Supplements:

Medication/Supplement	Reason for Use	Dose/Frequency	Started	Ended

If other than yourself, who is responsible for your bill?

Name: ___________________________________ Relationship:______________________

Mailing Address:____

Home Phone: ____________________________ Cell Phone: ___________________________

Email: ________________________________ Preferred Contact: Home Cell Email

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I certify that the above information is accurate and up to date.

I certify that I am aware of the following policies and that I will provide payment if and when necessary.

- **Cancellation Fee:** We understand that unexpected conflicts and last minute emergencies come up. Phone and virtual sessions are available to all clients who cannot make it to their appointment but do not want to reschedule. If you can no longer make your scheduled appointment, please call us at 201-653-6036 or email expertnutritionandwellness@gmail.com as soon as possible. Cancellations made less than 24 hours (but earlier than 4 hours - see **late cancel fee**) in advance will be charged a $50 fee.
- **Late Payment Fee:** Clients will be reminded of an unpaid invoice 3 days after the invoice is sent. However, for every additional 3 days the invoice goes unpaid, a late payment fee of $20 will be charged.
- **No Show & Late Cancellation Fee:** Clients who do not show to their scheduled appointment or who cancel within 4 hours of their appointment will be responsible for 100% of the usual fee.

I certify that if my bill is not submitted and/or accepted by insurance, my bill will be paid in full by myself or the individual listed above as being responsible for my bill.

*Patient Signature: ____ Date:_________

*Responsible Party (other than patient): _______________________________

Date:_________