

PATIENT REGISTRATION (PLEASE PRINT)

PATIENT NAME: _____ MR MRS MISS MS TODAYS DATE: _____
D.O.B. _____ HOME PHONE: _____ WORK: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
MALE FEMALE MARITAL STATUS: MARRIED SINGLE WIDOWED SEPARATED DIVORCED AGE: _____
PATIENT'S OCCUPATION _____ EMPLOYER _____
Your personal E-mail address: _____

REFERRED TO THIS OFFICE BY: _____ PHONE _____ FAX _____

How did you hear about our Practice? _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD DEPENDANT PATIENT'S DRIVERS LICENSE# _____

PERSON RESPONSIBLE FOR BILL OR PARENT (COMPLETE ONLY IF DIFFERENT FROM PATIENT)

GUARANTOR NAME: _____ SOCIAL SECURITY NUMBER: _____
RELATIONSHIP TO PATIENT: (PLEASE CHECK): SELF SPOUSE OR PARENT GUARANTOR'S DATE OF BIRTH: _____
ADDRESS: _____ PHONE NUMBER: _____
EMPLOYER NAME: _____ EMPLOYER PHONE NUMBER: (____) _____
EMPLOYER ADDRESS: _____

PRIMARY INSURANCE INFORMATION:

PLAN NAME/INSURANCE NAME: _____ I.D. NUMBER: _____
ADDRESS: _____ GROUP NUMBER: _____
POLICY HOLDER: _____ EFFECTIVE DATE: _____
POLICY HOLDER'S SS#: _____ POLICY HOLDER'S D.O.B. _____ SEX: M / F
POLICY HOLDERS EMPLOYER AND EMPLOYERS PHONE: _____

SECONDARY INSURANCE INFORMATION:

PLAN NAME/INSURANCE NAME: _____ I.D. NUMBER: _____
ADDRESS: _____ GROUP NUMBER: _____
POLICY HOLDER: _____ EFFECTIVE DATE: _____
POLICY HOLDER'S SS#: _____ POLICY HOLDER'S D.O.B. _____ SEX: M / F
POLICY HOLDERS EMPLOYER AND EMPLOYERS PHONE _____

WHO TO CALL IN THE EVENT OF AN EMERGENCY:

NAME: _____ RELATIONSHIP: _____
HOME PHONE _____ WORK PHONE: _____ CELL PHONE # _____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y N IF YES, PLEASE NOTIFY THE RECEPTIONIST

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS BILL TO MY INSURANCE COMPANY, AND REQUEST PAYMENT OF BENEFITS TO DR ROBERT A. KANTER OR NANCY L. NILES. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT WHETHER OR NOT COVERED BY INSURANCE.

SIGNATURE _____ DATE _____
THIS FORM MUST BE UPDATED, ALONG WITH PATIENTS CURRENT PHOTO ID AND INSURANCE CARD COPIES, KEPT ON FILE

SIGNATURE _____ DATE _____
THIS FORM MUST BE UPDATED, ALONG WITH PATIENTS CURRENT PHOTO ID AND INSURANCE CARD COPIES, KEPT ON FILE

PLEASE PROVIDE RECEPTIONIST WITH YOUR CURRENT IDENTIFICATION CARD, CURRENT INSURANCE CARD AND UPDATE ALL INFORMATION ANNUALLY TO EXPEDITE INSURANCE CARRIER PAYMENTS, WITH THE UNDERSTANDING THAT THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL FEES. ALL CO-PAYS ARE DUE AT TIME OF SERVICE. CO-PAYS WHICH PATIENT REQUESTS TO BE BILLED WILL BE CHARGED A FEE FOR BILLING SERVICES.

CALCIUM ASSESSMENT

Question	Answer	Calculate	Total
On average, how many 8 oz. glasses of milk per day?		Answer X 300	
On average, how many servings (1/2 cup cooked) of deep-green vegetables (see below) per day?		Answer X 150	
On average, how many servings (1 oz.) ¹ of cheese per day?		Answer X 200	
On average, how many servings (1 cup) of yogurt per day?		Answer X 400	
On average, how many servings (1/2 cup) of ice cream per day?		Answer X 85	
On average, how many servings of calcium fortified juices (orange juice, 1 cup, etc.) per day?		Answer X 300	
On average, how many servings of canned salmon or sardines (3 oz.) per day?		Answer X 150	
YOUR AVERAGE DAILY CALCIUM INTAKE IS:			

¹1 oz. of cheese is a Kraft single or a string cheese

SOURCES OF CALCIUM

	Milligrams		Milligrams
MILK		FISH	
Skim Milk, 8 ounces	302	Sardines with bones, 3 ounces	370
Whole Milk, 8 ounces	291	Canned salmon with bones, 3 ounces	180
Low fat chocolate milk, 8 ounces	287	VEGETABLES	
Buttermilk, 8 ounces	285	Kale, frozen, chopped, 1 cup	179
YOGURT		Broccoli, cooked, 1 cup	178
Nonfat Yogurt, 8 ounces	452	Collards, frozen, chopped, 1 cup	357
Low fat Yogurt, 8 ounces	415	Turnip greens, cooked, 1 cup	200
Frozen Yogurt, ½ cup	90	OTHER	
CHEESE		Calcium fortified Orange Juice, 1 cup	300
Goat Cheese (hard), 1 ounce	254	Chocolate Pudding, ½ cup	161
Part skim Mozzarella, 1 ounce	183	Vanilla Ice Cream, ½ cup	85
American Cheese, 1 ounce	174	Almonds, ¼ cup	81
Low fat Cottage Cheese, 1 cup	155	Kidney Beans, cooked, ½ cup	143
Feta, 1 ounce	140	Edamame, ½ cup	197
Grated Parmesan, 1 tablespoon	69	Egg, 1 whole, cooked	55

Please bring all supplement bottles to your appointment (vitamins, minerals, calcium supplements, herbs, anti-oxidants, etc.)

