



GENERAL NUTRITION ASSESSMENT FORM

Today's date:						
PATIENT INFORMATION						
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid	
Birth Date: / /		Age:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Social Security Number: - -			E-mail:			
Street Address:			Apt:	City:	State: Zip code:	
Home Phone: ()		Cell Phone: ()		Work Phone: ()		
Occupation:		Employer:		Employer Phone No.: ()		
In Case of Emergency, Contact:		Relationship:	Emergency Contact Number: Cell/Home: () Work: ()			

INSURANCE INFORMATION		
Full Name of Insured (if other than patient):		
Primary Insurance:	Group no.:	Policy no.:
Secondary Insurance (if applicable):	Group no.:	Policy no.:

VISIT INFORMATION	
Reason for Visit / Referral:	
Referring Physician:	Office no.:
Primary Care physician:	Office no.:

<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Surgical Associates at Virginia Hospital Center or insurance company to release any information required to process my claims.</p>	
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Patient/Guardian signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date

Name: _____

WEIGHT HISTORY

Height:	Current Weight:	Goal Weight:	
Heaviest Weight:	When?	Lowest Adult Weight:	When?

CURRENT MEDICATIONS

Please list all medications you are currently taking.

MEDICAL HISTORY

Do you have a history of:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:			

FAMILY HISTORY

Does your family have a history of:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:			

Name: _____

CURRENT DIET

Describe your current diet:

GENERAL NUTRITION HISTORY

How often do you eat out at restaurants?

Do you currently exercise? Yes No

If so, what is your routine?

Do you have any food allergies/intolerances? Yes No

If so please list:

Do you take any supplements/vitamins? Yes No

If so please list

What would you like to achieve from visiting with me?

Do you see any barriers to achieving this goal?

Name: _____

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

Please read the following office policies. We would like for you to read and sign accordingly. Thank you for choosing Surgical Associates at Virginia Hospital Center.

It is your responsibility to be aware of your insurance policy. Please provide us with a current insurance card at the time of check-in. You will be asked at all subsequent visits if your insurance and/or demographic information has changed. If you fail to give our office your new insurance card, you may be responsible for the full office charge. You are required to pay any applicable co-pays or current balances at the time of check-in unless you have made prior arrangements with the Practice Administrator.

Surgical Associates at Virginia Hospital Center is not responsible if you fail to obtain the required authorization. If a referral is required for your insurance, you - the patient - are responsible to obtain the referral prior to your visit from your Primary Care Physician. If you do not have the required referral at the time of your appointment, payment will be due at the time of service. If there are any issues regarding your appointment, we can reschedule your appointment at your convenience.

If you are not able to keep your appointment, please provide 1 (one) business day notice. Failure to provide appropriate notice will result in a \$35 fee for the missed appointment. We understand that emergencies happen and will take into consideration before any chargers are applied to your account.

Surgical Associates at Virginia Hospital Center will make every attempt to ensure you are seen in a timely manner. However our surgeons are occasionally called to emergencies. This may delay your appointment or you may be asked to reschedule your appointment. We appreciate your patience and understanding.

I have read the above policy.

Patient Name

Signature of Patient (or Parent/Legal guardian)

Name of Parent/Legal Guardian (if applicable)

Date