



Today's Date: ____/____/____
 Patient Name: _____
 Patient's Phone Number: _____ DOB: ____/____/____
 Address: _____

Insurance Carrier: _____ Subscriber Name: _____
 Subscriber DOB: ____/____/____ Subscriber Relationship to Patient: _____
 ID Number: _____ Insurance Company Phone Number: _____

Referring Provider: _____ Phone Number: _____
 NPI: _____ Fax Number: _____
 Do you want an update on this patient after their first appointment? Yes No

*In network: BCBS. Not currently accepting Medicare/Medicaid at this time.
 We can provide a superbill for clients to submit to insurance for reimbursement if we are not in network.*

Medical Diagnosis (check all that apply or use blank spaces as needed)

<input type="checkbox"/>	F50.00	Anorexia Nervosa, unspecified	<input type="checkbox"/>	F50.2	Bulimia Nervosa
<input type="checkbox"/>	F50.01	Anorexia Nervosa, restricting type	<input type="checkbox"/>	F50.8	Other eating disorder
<input type="checkbox"/>	F50.02	Anorexia Nervosa, binge eating/purging type	<input type="checkbox"/>	F50.9	Eating disorder, unspecified
<input type="checkbox"/>	E11.____	Type 2 Diabetes	<input type="checkbox"/>	F50.81	Binge Eating Disorder
<input type="checkbox"/>	E10.____	Type 1 Diabetes	<input type="checkbox"/>	E16.2	Hypoglycemia, unspecified
<input type="checkbox"/>	Z68.51	BMI, pediatric, less than 5th percentile for age	<input type="checkbox"/>	R73.03	Pre-diabetes
<input type="checkbox"/>	Z68.52	BMI, Pediatric, 5th percentile to less than 85th percentile for age	<input type="checkbox"/>	R62.51	Failure to Thrive, Child
<input type="checkbox"/>	Z68.53	BMI, Pediatric, 85th percentile to less than 95th percentile for age	<input type="checkbox"/>	R63.4	Abnormal weight loss
<input type="checkbox"/>	Z68.54	BMI, Pediatric, greater than or equal to 95th percentile for age	<input type="checkbox"/>	R63.5	Abnormal weight gain, not during pregnancy
<input type="checkbox"/>	Z68.1	BMI 19 or less, adult	<input type="checkbox"/>	K90.0	Celiac Disease
<input type="checkbox"/>			<input type="checkbox"/>		
<input type="checkbox"/>			<input type="checkbox"/>		