

**Banister & Associates LLC
Nutrition Consulting
and Management**

Mercy Tower, Suite 508
4200 W. Memorial Road
Oklahoma City, OK 73120
405.755.7561

Medical/Nutrition History

Referred by _____ Date _____

To be filled out by the Client

Client's Name _____ Parent's Name (if client is a minor) _____

Date of birth _____ Sex _____ Age _____ SSN _____

Address _____

City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Email Address _____

Occupation/Employer _____ Work hours _____

Marital Status: Single Married Divorced Separated Widowed

Number of persons in household Adults _____ Children _____

****PLEASE FILL OUT INSURANCE INFORMATION COMPLETELY!** Thank you!**

Insurance Company _____ Policy # _____

Secondary Insurance _____ Policy # _____

Subscriber's Name _____

Subscriber's SSN _____

Employer of Subscriber _____

Relationship to Subscriber _____

Primary Physician _____ Date of last checkup _____

Reason for referral to this office? _____

How long have you had this condition/disease? _____

Under other physician's care? Y N If so, who and for what? _____

Personal Medical History: Check conditions that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart disease or stroke | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Obesity | <input type="checkbox"/> Major surgery |
| <input type="checkbox"/> Thyroid/other | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Hormone conditions | <input type="checkbox"/> Dentures | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chewing problems | <input type="checkbox"/> Physical handicaps |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Food sensitivities | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other allergies | |
| | <input type="checkbox"/> Gastrointestinal disorders | |

Family Medical History: Check conditions that apply

- | | |
|--|---|
| <input type="checkbox"/> Heart disease or stroke | <input type="checkbox"/> Food allergies |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Thyroid/other | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hormone conditions | <input type="checkbox"/> Gallbladder disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gastrointestinal disorders |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Other allergies |
| <input type="checkbox"/> Food sensitivities | |
| <input type="checkbox"/> Other | |

List all medications you are taking <i>Use the back if you need more space</i>	Time of Day	Amount	Purpose

Reactions to any medications _____

Alcohol intake: # drinks per day _____ per week _____

Type of alcohol _____

Tobacco usage: smoker non smoker quit smoking _____ years ago

Chewing tobacco: Y N

Height _____ Present Weight _____ Usual Weight _____ Highest Weight _____

Goal Weight _____ Pounds gained this year _____ Pounds lost this year _____

Is anyone in your family overweight? Y N If so, who? _____

To be filled out by the Client

For dietitian use only

<p>Have you ever taken diet pills? Y N</p> <p>Have you ever been on a special diet before? Y N</p> <p>If yes, what type and when? _____</p> <p>_____</p> <p>Did you stay on the diet? Y N</p> <p>List any problems you had with the diet? _____</p> <p>_____</p> <p>Have you ever seen a registered dietitian before? Y N</p> <p>Is so, where? _____</p> <p>List any vitamins/minerals or any other kinds of supplements you are taking. _____</p> <p>_____</p>	<p>Diet History:</p> <p>Supplements:</p>
<p>Anyone else in the household on special foods/diets? Y N</p> <p>If so, what type of foods/diets? _____</p> <p>Who cooks meals? _____</p> <p>Who does the grocery shopping? _____</p> <p>Out of 21 meals/week, what % is prepared at home? _____</p> <p>How are most foods prepared at home? <input type="checkbox"/> Baked <input type="checkbox"/> Boiled <input type="checkbox"/> Fried <input type="checkbox"/> Other</p> <p>How often do you go out to eat per week including carryout or delivery? _____</p> <p>What restaurants do you frequent? _____</p> <p>_____</p>	
<p>Do you exercise regularly? Y N</p> <p>If so, what type? _____</p> <p>Times per week _____ Total number of hours per week _____</p> <p>Where do you do your exercise? _____</p>	
<p>Identify your stress level High Moderate Low</p> <p>On an average, how many hours of sleep do you get? _____</p> <p>Any personal problems in the last 12 months? (family problems, death of family members, marital problems, divorce, job change, accidents, illness) _____</p> <p>_____</p>	

	Good	Fair	Poor
How would you generally describe your eating habits?			
Has your appetite changed recently?		Y	N
How many times a day do you eat? _____			
How long does it take to complete a meal? _____			
Do you have trouble eating, chewing or swallowing?		Y	N
Have you ever gone on an eating binge?		Y	N
Does this still occur?		Y	N
<hr/>			
Have you ever induced vomiting after you eat?		Y	N
Do you ever feel extremely guilty after eating?		Y	N
Do you ever find yourself preoccupied with food?		Y	N
Do you avoid foods that contain sugar or fat?		Y	N
Have you ever taken laxatives or diuretics to lose weight?		Y	N
Do you skip meals?			
Which meal? _____			
Where do you eat most of your meals at home?			
Do you watch TV when you eat?		Y	N
Do you clean your plate even when full?		Y	N
Do you eat standing up?		Y	N
Do you eat when preparing food or storing leftovers?		Y	N
At work, do you have the following items available?			
<input type="checkbox"/> cafeteria			
<input type="checkbox"/> vending machine			
<input type="checkbox"/> microwave			
Do you feel that you will be able to follow a nutrition program?		Y	N
Explain _____			
Do you salt food at the table regularly?		Y	N
Do you drink coffee or tea?		Y	N
If yes, how much each day _____			
Does your weight depress you?		Y	N
Do your emotions/feelings affect your food choices?		Y	N
<hr/>			
What are your nutrition related goals? _____			Goals:

What help do you want from a registered dietitian? _____ _____ _____ _____ _____	Expectations:
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To be filled out by the Client

For dietitian use only

For patients with Diabetes:

Are you monitoring your blood glucose? Y N

If yes, how many times per week: _____

Please indicate your blood sugar readings:

Time of Day	Blood Glucose Reading

What problems with your diabetes management are you experiencing at this time?

Diabetic Management:

Please continue to the next page for food diary information.

Food Diary:

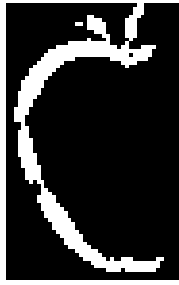
Please include records of intake for one week-day and one weekend day. Include all meals, snacks and drinks.

Day 1

Date	Time	Food	Amount	Portion Size

Day 2

Date	Time	Food	Amount	Portion Size



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Carol Banister, RD/LD, MS, CDE
Paula Partlow, RD/LD, MS
Holly Campbell, RD/LD, MS

OFFICE PROCEDURES

CONSULTATION FEES: Medical Nutrition Therapy fees range from \$85.00 - \$140.00, depending on amount of time, as well as complexity of medical nutritional issues.

INSURANCE: Banister & Associates are participating providers for the following: Aetna US Healthcare, Blue Cross/Blue Shield of Oklahoma, PPO Oklahoma First Health, Community Care HMO, Preferred Community Choice, Health Choice, PacificCare PPO, Coventry Health Care, United Healthcare and Medicare.

With appropriate authorization/referral from your primary care physician, insurance will be filed on your behalf. All co-pays are due at the time of service. Remember your insurance benefits are a contractual agreement between you and your insurance company, Banister and Associates can never guarantee what you and your insurance company have contracted as your covered benefits.

Any insurance company not listed above may cover medical nutrition therapy, but it is your responsibility to contact your insurance company to determine your benefits. We request that you pay for services at the time they are provided. We will file for your insurance coverage for you. If we receive payment, we will then reimburse you.

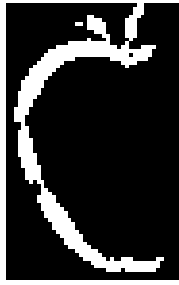
**YOU, THE PATIENT, ARE RESPONSIBLE FOR FEES
INCURRED SHOULD YOUR INSURANCE DENY
PAYMENT.**

We accept cash, checks, Visa and Master Card.

I have read, understand and accept my responsibility regarding my insurance and payment for professional services provided to me.

Signature and Date

Thank You.



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Carol Banister, RD/LD, MS, CDE
Paula Partlow, RD/LD, MS
Holly Campbell, RD/LD, MS

CANCELLATION POLICY

We intentionally have a fixed and moderate patient load so that we can provide the best quality of care for you. When we have a regular scheduled appointment, that time is reserved solely for you, as if you “rented” that space. Because this is a small business, we cannot afford to go uncompensated for the time we have set aside for you. If you must cancel an appointment and do so at least 24 hours in advance, you will not be charged for your missed appointment. If you cancel less than 24 hours in advance you will be charged for your missed appointment.

Charge for a 1 hour missed appointment - \$140.00
Charge for a 45 min missed appointment - \$120.00
Charge for a 30 min missed appointment - \$85.00

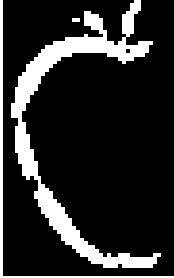
These charges are not reimbursable by your insurance company. This policy is not meant to be punitive, harsh, or judgmental. It is designed only to keep our practice viable.

Thank you for understanding our policy. Please let us know if you have questions or concerns.

I have read, understand, and agree to this policy.

Signature
(Update April 2010)

Date



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RECORDS RELEASE

Please list names of physicians and/or counselors you are currently under the medical care of. Please indicate (X) if it is agreeable to you for us to contact these health care providers if necessary to discuss your medical needs/care, obtain lab work, provide written report(s) concerning your medical care.

Health Care Provider	Phone	Address	(X) Yes	(X) No

● Patient/or Guardian Signature _____ Date _____

RECEIPT OF PRIVACY POLICY:

I acknowledge receiving a copy to read of the Notice of Privacy Practice for Banister and Associates Nutrition Consulting.

● Patient/or Guardian Signature _____ Date _____

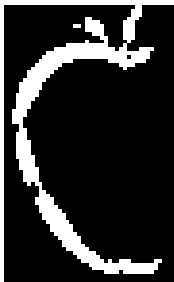
CONTACT PHONE NUMBERS:

Please indicate at least two phone numbers we may contact you at if needed to confirm appointment, possibly change an appointment due to illness or emergency of the dietitian, i.e., work, home, cell.

Home # _____ Work # _____ Cell # _____

I am agreeable to being contacted at the phone numbers listed above. Please list any privacy guidelines you would like us to specifically respect:

● Patient/or Guardian Signature _____ Date _____



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ASSIGNMENT OF BENEFITS

(Please disregard this page if you are not using insurance coverage.)

I acknowledge receipt of medical services and authorize the release of any medical information necessary to process this claim for health care payment only.

I hereby instruct and direct the *insurance company designated below to issue direct payment to Banister and Associates for the medical expenses allowed under my current insurance policy. Such payment shall be applied towards the total charges for the services rendered on my behalf by Banister and Associates and that are invoiced to my insurance company. This assignment is a direct assignment of my rights and benefits under my insurance policy. I agree to pay to Banister and Associates, in a current and timely manner, any balance of medical charges and expenses over and above the amount of the allowed insurance payment, including charges for any services not covered by insurance, co-pays, expenses and any deductibles that are required pursuant to the above-mentioned insurance policy.

*Please remember it is your responsibility to determine if your insurance policy will cover the services of a registered dietitian to provide medical nutrition therapy to you.

Patient's Signature Date

Patient's Name Printed Social Security No.

Patient's Agent or Guarantor Relationship

Reason for Other Patient's Signature

Name of **Primary** Insurance Co: _____

Group Number/Policy Number: _____

Name of **Secondary** Insurance Co: _____

Group Number/Policy Number: _____

Medicare – Claim Number: _____

Effective Date (Part A) _____ Effective Date (Part B) _____