Bryn Arata
NUTRITION

Registration Form

Patient's Name:_____Date of Birth:_____

Address:_____Phone:_____

Who is responsible for payment?_____Relationship to patient:_____

Mother's Information
(Pediatric patient only)

Name:_____Email:_____

Best Contact Number:_____

Father's Information
(Pediatric patient only)

Name:_____Email:_____

Best Contact Number:_____

Referral Information

Referred by?_____

Who is your primary care physician?_____

Please provide their practice name, address, phone number:_____

_____

- I realize that I will pay a $50 deposit for scheduling the appointment which will be subtracted from the final fee after services rendered.
- I realize that I am obligated to pay in full for services when they are rendered. Cash, check, Venmo or PayPal are the only methods of payment accepted at this time.
- I realize that I am responsible for submitting information needed to my insurance company for reimbursement.
- I realize that if I do not give a 48 hour cancellation notice, I will lose my deposit.

Signature: _____Date:_____