LEXSTART NUTRITION

LexStart Nutrition, LLC Basic Information

Name: _____ Sex: _____ Age: _____ Birthdate: _____

Email: _____Opt-in to Newsletter? (YES/NO)

Address (City, State, Zip Code): _____

Phone (Home/Cell/Work): _____

Height: _____ Current Weight: _____Usual Weight: _____Goal Weight: _____

Any recent weight changes? (YES/NO) If so, over what period of time?_____

Occupation: _____ Employer: _____

Primary Nutrition Concern: _____

Other Medical Problem (s): _____

Family Medical History: _____

Medications/Supplements: _____

Food Allergies: _____ Exercise Routine: _____

Current Food Intake: _____

Guardian Name (If Applicable): _____ Guardian Phone: _____

Guardian's Email Address: _____

Guardian's Address: _____

Insurance Information

Primary Insurance: _____ Member ID #: _____ Group #: _____
Phone (of insurance company): _____ Name of Insured: _____
Name of Employer (for insurance company): _____ Birthdate: _____

Secondary Insurance:_____ Member ID #: _____ Group #: _____
Phone (of insurance company): _____ Name of Insured: _____
Name of Employer (for insurance company): _____ Birthdate: _____

I authorize the release of any medical information necessary to process any claims. In the event that my insurance company will not cover nutrition services, I will be responsible for payment.

_____ _____
Signature **Date**

Emily McGlone, MS, RD, LD, CLT | lexstartnutrition@gmail.com | (859)429-8935
90 Southport Dr., Lexington, KY, 40503
www.lexstartnutrition@gmail.com