Sharon Saka Associates, Inc. www.sakadiet.com

2 Executive Blvd – Suite 203
Suffern, NY 10901

Phone: (845) 357-0166
sakadiet@gmail.com

Today's Date: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Social Security Number: _____

E-mail: _____

Sex __M __F Marital Status: ___Single ___Married __Other

Age: _____ Date of Birth: _____

Vitamins/Medications: _____

Amount of Physical Activity: _____

Doctor's Name: _____

Doctor's Address: _____

Please Check *Any* of the Following that Apply:

__ Diabetes __ High Blood Pressure __ Kidney Disease

__ Food Allergies __ High Cholesterol __ Liver Disease

__ Gall Bladder Disease __ Hypoglycemia

Other Reason for Appointment _____

_____

Insurance Company _____

Subscriber Name _____ Subscriber DOB _____

Relationship to Subscriber: __Self __Spouse __Child __Other _____

PLEASE NOTE: We will submit the claim directly if we participate with your insurance company, **BUT**, if you are not covered for nutritional counseling under your policy, and the claim is not paid, the balance due is your responsibility. If you have a referral, please keep track of number of visits, expiration date, etc.

Patient/Guardian Signature _____