

**Eating Disorder Program Pre-registration Form**

**Please complete the information below so that the patient can be registered and insurance benefits reviewed.**

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| Patient’s full name (including middle name) |  |
| Patient’s date of birth |  |
| Home address |  |
| Parent’s full name (insurance policyholder) and date of birth |  |
| Parent’s cell phone number |  |
| Name of parent’s employer (insurance policyholder |  |
| Primary Care Doctor/Pediatrician’s nameand address |  |
| Primary Care Doctor’s phone number |  |
| Requested Services |  Nutrition  Medical  Psychology  |

* **Please email or fax a copy of the front and back of your child’s insurance card to: (****peyoung@cnmc.org** and **ffitzhug@cnmc.org ) or fax (****202-237-0694****)**
* **Please fax all required documents to “Attention: Petrinia Young.”**
* **If a referral is required by your insurance, it can also be faxed or scanned.**