



**Storch Medical Nutrition Center**

*A Fresh Start Towards Health*

Date: \_\_\_\_\_

Dear \_\_\_\_\_:

Welcome to Storch Medical Nutrition Center (SMNC) and the Tabula Rasa Nutrition Program. Each of us has a health history that is unique. Understanding your history will help us to diagnose and treat your concerns. It will be useful to us if you take a few minutes to complete the attached forms *prior to your visit*. We will review them with you during your consultation. The information allows us to focus on the most important medical and nutritional issues in your life. If you need any assistance or clarification to complete these forms, the office staff will be glad to answer your questions. ***Please bring the forms with you to your first appointment.***

The Tabula Rasa Nutrition Program consists of an initial consult with the dietitian followed by a weight loss program (consisting of cycles of 10-week or 12-week courses). For patients with a participating insurance plan, a letter is enclosed that you can provide to your primary care physician explaining our program and requesting a referral for multiple visits. The dietitian will review the program options with you at your initial visit. In a few cases, patients are not appropriate for the weight loss program.

For patients seeing a physician, your first visit will include an assessment and exam. ***A complete nutrition plan will be provided at the following appointment with one of our Registered Dietitians, as necessary.***

We look forward to serving you as a new patient. Your appointment is as follows:

Practitioner(s): \_\_\_\_\_

Date(s): \_\_\_\_\_

Time(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sincerely yours,

Storch Medical Nutrition Center

**Storch Medical Nutrition Center  
Patient Information**

Date Form Completed: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Check One: Single [ ] Married [ ] Widowed [ ] Divorced [ ]

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Spouse's Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_

How Did You First Learn About Us: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

**Please present your insurance I.D. Card to the receptionist.**

Social Security #: \_\_\_\_\_

Primary Insurance  
I.D. # \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance:  
I.D. # \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Policy Holder if Other Than Yourself: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Policy Holder Social Security #: \_\_\_\_\_

I authorize payment of medical insurance benefits to Storch Medical Nutrition Center for services rendered to me, and the release of any medical or other information necessary to process my insurance claims.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date

**7 Columbia Turnpike, Florham Park, NJ 07932**

**973-765-WELL**

**Storch Medical Nutrition Center**  
**Nutrition / Metabolism Assessment**

Name: \_\_\_\_\_ Date Form Completed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<b>Lifestyle</b>
------------------

	<u>Yes</u>	<u>No</u>
Do you exercise regularly?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how often and what type? _____		
Do you smoke currently or have you smoked in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much? _____		
Do you consume alcohol?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how often? _____		
Do you , or have you ever, binged or purged? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat in response to stress? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any food cravings? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		
Do you skip meals regularly? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which ones? _____		
Do you eat in the middle of the night? .....	<input type="checkbox"/>	<input type="checkbox"/>
How many meals a week do you eat at a restaurant or take out? _____		
What type of restaurants? _____		
Who manages your meals (food shopping, cooking)? _____		

<b>Weight History</b>
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	<u>Yes</u>	<u>No</u>
Have you gained or lost weight in the last 6 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much? _____		
Does your family have a history of weight problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____		
What is your heaviest adult weight? _____ lowest? _____		
when? _____ when? _____		
What weight control programs have you tried?		
_____		
_____		
Which one were you most successful with? _____		
Why? _____		
Which one were you least successful with? _____		
Why? _____		
Have you ever used weight loss medications? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____		

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Food Intake**

**Please give a sample of a typical day's food intake:**

Breakfast: \_\_\_\_\_  
\_\_\_\_\_

Snack: \_\_\_\_\_  
\_\_\_\_\_

Lunch: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Snack: \_\_\_\_\_  
\_\_\_\_\_

Dinner: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Snack: \_\_\_\_\_  
\_\_\_\_\_

# STUDY OF SYSTEMS

Name: \_\_\_\_\_ Date Form Completed: \_\_\_\_\_

**Check either Yes or No for each item—Except where applies to only male or female**

Conditions	Y	N	Conditions	Y	N	Conditions	Y	N
<b>G E N E R A L</b>	Fever		Appetite Poor		<b>I N T E S T I N A L</b>		<b>N E C K</b>	
	Chills		Indigestion/Heartburn					
	Bruise Easily		Nausea					
	Swollen Glands		Vomiting Blood					
	Loss of Memory		Abdominal Pain/Cramps					
	General Weakness		Abdominal Tension					
	Aches/Pains		Diarrhea					
<b>H E A D</b>	Double Vision		Constipation		<b>K I D N E Y</b>		<b>P S Y C H O L O G I C A L</b>	
	Blurred Vision		Bowel Habit Changes					
	Halos Around Lights		Rectum Blood Passage					
	Buzzing/Ringing in Ears		Black Tar-Type Bowel Movements					
	Nosebleeds		Up Nights to Urinate					
	Sinus Problems		Blood in Urine					
	Swallowing Problems		Burning/Pain w/ Urination					
	Change in Taste		Frequent Urination					
	Deafness		Problem Passing Urine					
	Persistent Hoarseness		<b>N E U R O</b>					
Severe Headaches								
Rash								
<b>S K I N</b>	Changing Moles		Joint Pains		<b>M A L E</b>		<b>F E M A L E</b>	
	Dry Skin		Joint Swelling					
	Lesions		Muscle Strength Loss					
	Change In Pigmentation		Pains in Back					
<b>H E A R T / L U N G S</b>	Irregular Heartbeat		<b>E N D O C R I N E</b>		<b>S L E E P</b>		<b>O T H E R</b>	
	Shortness of Breath							
	Low Exercise Tolerance							
	Heart Flutters							
	Chest Pains							
	Frequent Coughs							
	Cough Up Blood							
	Wheezing							
	Night Sweats							
	Swollen Ankles							
	Cramps in Legs							
	Heart Murmur							
	Stress Test Done							
	If yes, results:							
		Constant Thirst		Most Always Cold		Penis Discharge		
		Too Warm Most Times		Very Sluggish or Tired		Sore on Penis		
		Numbness/Tingling of Extremities		Libido Dysfunction		Erection Difficulties		
		Jumpy/Nervous		Snore		Breast Lump		
		Wake Up Frequently At Night		Fall Asleep While Driving		Nipple Discharge		
		Fall Asleep While Watching TV		Insomnia		Non-Period Bleeding/Spotting		
		Daytime Sleepiness		Daytime Sleepiness		Hot Flashes		
		Fatigue		Fatigue		Possibly Pregnant		
						Change in Periods		
						Pain Other Than With Periods		
						Please List Any Other Problems Below:		



**Storch Medical Nutrition Center**  
*Medication List*

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Please List Any Allergies to Medications: \_\_\_\_\_

Local Pharmacy Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Mail Order Pharmacy Name (if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Please List Your Current Medications**

Name	Dose	Times Per Day	How Long Have You Been Taking?

**Please List Your Current Vitamin, Mineral & Herbal Supplements**

Name	Dose	Times Per Day	How Long Have You Been Taking?

*Medical Summary / Family History*

Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

**Please List Your Medical Problems**

Medical Problem	When Was This Diagnosed?

**Family History**

Please Give A Summary of Your Family's Health History

Father  
\_\_\_\_\_  
\_\_\_\_\_

Mother  
\_\_\_\_\_  
\_\_\_\_\_

Brother (s)  
\_\_\_\_\_  
\_\_\_\_\_

Sister (s)  
\_\_\_\_\_  
\_\_\_\_\_

Other  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please List Your Other Physicians**

Name: \_\_\_\_\_ Date Form Completed: \_\_\_\_\_

Your Primary Doctor: \_\_\_\_\_

Medical Group: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Other Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Medical Group: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Other Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Medical Group: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Other Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Medical Group: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Other Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Medical Group: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Other Doctor: \_\_\_\_\_

Specialty: \_\_\_\_\_

Medical Group: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**Storch Medical Nutrition Center**

*A Fresh Start Towards Health*

Please Sign and Date

## Office Policies

To allow us to control our cost of providing care, the following policies have become vital. Your understanding is appreciated.

### Cancellations

- **24-hour notice is required for cancellations with the Physician during business hours (Mon-Thurs); if less than 24-hour notice is given a \$25 fee will be charged to your account.**
- **If less than 24-hour notice is given for an initial visit a \$100 fee will be charged.**

### Prescription Refills

- **3 days notice is requested for prescription refills.** This allows time for the prescription to be cleared by the doctor.
- Please do not wait until you are out of medication to contact your pharmacy.

### Payment

- Participating insurances will be billed for medical visits; the co-payment is due at the time of visit. You will be responsible for any remaining balances.
- Payment is required up front for medical visits for any insurance plans in which we do not participate.
- See Fee Schedule and Policy Sheet for the Tabula Rasa Nutrition Program for information regarding visits with the Registered Dietitians.
- For your convenience, SMNC accepts cash, checks, Visa, MasterCard, and Discover.

### Referrals

- You are responsible for obtaining all necessary referrals for your appointments.
- Please keep track of remaining referrals and notify your primary care physician when more are needed.

### Testing / Laboratory Results

- Normal test results will be discussed with patients during regular office visits.
- If you wish to discuss a normal result, please make an appointment.

### Appointments

- Routine follow-up appointments with the doctors are booked 4 per hour. Most physicians now book 6 to 10 patients per hour.
- If you need an extended visit, please tell the receptionist. You will most likely need to wait longer, because we will need to allow more time for your visit.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_



**Storch Medical Nutrition Center**

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Please Sign and Date

## Tabula Rasa Nutrition Program Fee Schedule & Policy Sheet

### Fee Schedule For Non-Participating Insurance Plans

- As a courtesy, we offer the following discounted fee schedule for patients without participating insurance plans:

Initial Consult:	\$150	
Shaping Habits Program:	\$400	5 educational classes and 5 one-on-one sessions
Shaping Kids' Habits Program:	\$550	10 one-on-one sessions
HMR Meal Replacement Program:	\$400	12 educational classes

- Above fee schedule for programs includes a \$50 administrative fee.
- Payment is due at the initial visit.
- If joining a program you may pay 50% of the program cost at your initial consult and the balance at your next visit.
- Private programs can be arranged as necessary.

### Participating Insurance Plans

- Visits will be billed on a weekly basis; co-payment is due at the time of visit.
- Visits with the Registered Dietitian are billed based on the amount of time the visit requires.
- Please verify coverage with your insurance company prior to your visit. Your insurance plan may determine eligibility for coverage based on factors such as diagnoses and medical conditions.
- You must bring your insurance card and completed referral from your primary care physician. We also suggest a prescription from your primary care physician, which includes diagnosis codes.
- You are responsible for obtaining all necessary referrals for your appointments. Please keep track of remaining referrals and notify your primary care physician when more are needed.
- A referral from your primary care physician does not guarantee payment, and you will, therefore, be responsible for any charges not covered by your insurance plan.
- Your insurance plan may require proof of progress (i.e. changes in weight or bloodwork) before approving additional visits.

**An administrative fee of \$50 is due at the time of enrollment in a program.**

### Cancellations / Missed Visits

- Cancellation Policy: 24-hour notice is required for appointments with the Registered Dietitian. If this notice is not received a charge of \$25 will be applied to your account.**
- If less than 24-hour notice is provided for an initial visit, a \$100 fee will be charged.**
- Prepayment of visit cost or copay is required following multiple cancellations to hold next appointment.
- Missed educational classes cannot be carried over to the next session. No make-up classes are offered.
- Missed one-on-one sessions must be completed within 14 weeks.
- Payments for private or class programs are non-refundable. A one-week grace period is provided after start of your program, less a \$100 administrative fee.

Signature: X

Date: \_\_\_\_\_

# **Directions to the Office**

## **7 Columbia Turnpike**

### **Florham Park, NJ 07932**

The office is located in a two-story brick building. It is at the intersection of Vreeland Road and Columbia Turnpike. We are on the first floor and you enter the building from the back parking lot.

*NOTE: Please be aware that Columbia Turnpike changes its name to South Orange Avenue in Livingston and is also known as Route 510.*

#### **From Route 24 East:**

- Take exit 2B (Florham Park, Route 510E) which will exit onto Route 510E
- At the 9th traffic light (intersection of Vreeland Road & Columbia Turnpike), turn right into our building driveway and park in the rear

#### **From Route 24 West:**

- Take exit 7C (JFK Parkway) and travel on JFK Parkway for 5 lights to South Orange Avenue (Route 510); make a left onto South Orange Avenue (Route 510 West)
- At the 5<sup>th</sup> traffic light (intersection of Vreeland Road & Columbia Turnpike), turn left into our building driveway and park in the rear

#### **From Route 287 North or South:**

- Take exit 37 (Route 24E, Springfield) and follow directions for Route 24E

#### **From South Orange Avenue or Columbia Turnpike (Route 510 Westbound):**

- Travel West on Route 510 into Florham Park
- South Orange Avenue changes its name to Columbia Turnpike as you travel past the Livingston Mall.
- At the intersection of Vreeland Road & Columbia Turnpike is our building; turn left into our building driveway and park in the rear

#### **From Route 10 East:**

- Make a right onto Ridgedale Avenue which is at the town borders of Whippany and East Hanover  
(Note: There are two Ridgedale Avenues. The correct Ridgedale Avenue is about 2 miles east of Rt. 287: do NOT turn on Ridgedale Avenue in Cedar Knolls/Parsippany which is just prior to the Rt. 287 entrance.)
- At the 3rd traffic light, turn left onto Columbia Turnpike (Route 510E)
- Turn right at the 3<sup>rd</sup> traffic light (intersection of Vreeland Road & Columbia Turnpike), turn right into our building driveway and park in the rear

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**Storch Medical Nutrition Center**  
**7 Columbia Turnpike, Florham Park, NJ 07932**

**973-765-9355**

**From Route 10 West:**

- Follow the Ridgedale Avenue, Florham Park exit off Route 10 (This is at the town borders of Whippany and East Hanover)
- At the end of the exit, turn left onto Ridgedale Avenue
- Turn left at the 4th traffic light onto Columbia Turnpike (Route 510E)
- Turn right at the 3<sup>rd</sup> traffic light (intersection of Vreeland Road & Columbia Turnpike), turn right into our building driveway and park in the rear

**From Garden State Parkway North:**

- Take exit 142 (Route 78E). Exit 142 will only allow you to travel east: therefore, you will have to make a U-turn at the next exit. There are signs posted for Route 78W to follow
- Route 78W will split into Route 78W and Route 24W. You will follow the signs for Route 24W
- Follow the directions above for Route 24W

**From Garden State Parkway South:**

- Take exit 142 (Route 78W)
- Route 78W will split into Route 78W and Route 24W. You will follow the signs for Route 24W
- Follow the directions above for Route 24W

**From New Jersey Turnpike (North and South):**

- Take exit 14 (Route 78W)
- Route 78W will split into Route 78W and Route 24W. You will follow the signs for Route 24W
- Follow the directions above for Route 24W